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ABSTRACT

Hearings on the status of medical education funded under the Medicare program are presented, with attention to how the program reimburses hospitals for medical education costs. The Social Security Act Amendments of 1983 provided for a radical reform in hospital payment. By the end of a 3-year phase-in period, the program was designed to set Medicare rates according to a national average payment per diagnosis related grouping. The scheme provided for urban and rural variations and payments, passthroughs for hospital incurred capital costs, and passthrough for the direct cost allocated with graduate medical education and other clinical training activities. An additional adjustment was allowed for the indirect costs of graduate medical education incurred by teaching hospitals, including such things as a sicker patient load, and resident training costs. A background paper covers: the nature of health education activities and the role of teaching hospitals in medical education, including the associated costs and current sources of financing; Medicare's historical and current policies for making payments to hospitals for the costs of education activities; and key issues that have been raised concerning current and future financing for medical education activities. (SW)

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S. Hrg. 98-1264

MEDICAL EDUCATION FUNDING BY MEDICARE

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

NINETY-EIGHTH CONGRESS

SECOND SESSION

OCTOBER 1, 1984

U.S. DEPARTMENT OF EDUCATION
NATIONAL INSTITUTE OF EDUCATION
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MEDICAL EDUCATION FUNDING BY MEDICARE

MONDAY, OCTOBER 1, 1984

U.S. SENATE,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON FINANCE,
Washington, DC.

The committee met, pursuant to notice, at 2 p.m., in room SD-215, Dirksen Senate Office Building, Hon. David Durenberger (chairman) presiding.

Present: Senator Durenberger.

[The press releases announcing the hearing, the opening statement of Senator Durenberger, and a background paper prepared by the committee staff follow:]

[Press Release No. 84-169]

SENATE FINANCE SUBCOMMITTEE ON HEALTH SETS HEARING ON MEDICAL EDUCATION FUNDING BY THE MEDICARE PROGRAM

Senator Dave Durenberger (R., Minn.), Chairman of the Subcommittee on Health of the Senate Committee on Finance, announced today that the subcommittee will hold a hearing on the status of medical education funded under the Medicare program.

The hearing will be held on Friday, September 21, beginning at 10 a.m. in Room SD-215 of the Dirksen Senate Office Building.

In announcing the hearing Senator Durenberger noted that, "When the Congress created the new prospective payment system for inpatient hospital services under medicare, cost reimbursement was retained for medical education and capital." In doing so, however, the Congress indicated a clear intent to consider new payment mechanisms for capital-related costs incurred after October of 1986. No such intent was expressed or implied with respect to either direct or indirect medical education costs. In fact, the so-called "medical education indirect cost pass-through" was not only retained but doubled because of our concern that the current diagnosis-related groups payment mechanism may not fully reflect the more intensive cases, presumed to be attracted to this Nation's teaching hospitals. The current method of financing medical education costs under the medicare program may or may not be the best or only way to do so. In fact, there is no intent on our part to accept the status quo without question. Certainly, in fulfilling our oversight responsibility and, in order to chart a course for the future, it is important to understand how the system is working. The purpose of this hearing is to do just that. The Subcommittee would like to review the current financing mechanism from the standpoint of which problems it has solved, it may have created, or it may have overlooked.

Senator Durenberger stated that the Subcommittee is interested in hearing from the Administration with respect to an overview of the current financing mechanism; and the medical education community with respect to what they believe to be the benefits and the problems with the present system and the objectives that will have to be met no matter what the financing mechanism. The Subcommittee is not interested at this time in any new financing mechanism but rather as complete an understanding as is possible for the present one.

Senate Finance Subcommittee on Health Reschedules Hearing on Medical Education Funding by the Medicare Program

[Press Release No. 84-169, Revised]

Senator Dave Durenberger (R., Minn.), Chairman of the Subcommittee on Health of the Senate Committee on Finance announced today that the hearing which had been scheduled for Friday, September 21, 1984 at 10:00 a.m. has been rescheduled.

The hearing will be held at 2 p.m. on Monday, October 1, 1984 in Room SD-215 of the Dirksen Senate Office Building.

Statement by Senator Dave Durenberger, Chairman of Health Subcommittee

The Social Security Act Amendments of 1983, provided for radical reform in the payment of hospitals under Part A of the Medicare Program. The new prospective payment system mandated by the act was designed to phase-in over a 3-year period. By the end of the phase-in, the Medicare rates for hospitals will be set according to a national average payment per diagnosis-related grouping.

In recognition of the disparate locations and service and training mix for hospitals, the Congress provided under the new scheme for urban and rural variations in payment; pass-throughs for hospital incurred capital costs; and pass-through for the direct costs allocated with graduate medical education and other clinical training activities. An additional adjustment was allowed for the indirect costs of graduate medical education incurred by teaching hospitals.

This adjustment for indirect medical education expenses accounts for the high costs of teaching hospitals due to factors such as a sick patient load, a more elaborate and expensive medical technological capacity, and those additional costs allocated with the training of residents. The DRG system, used for Medicare prospective payment, is relatively insensitive to severity of illness so this indirect expense is in part a proxy for severity. As improved methods of establishing severity are devised, these developments will be incorporated into the overall DRG payment system. These refinements will make some portion of this indirect expense unnecessary. The remainder of the adjustment, based on broad assumption, about the nature of teaching hospitals, also requires close scrutiny.

Congress has set the end of the phase-in period for prospective payment 2 years from today, as the deadline for setting in place a new methodology under which the capital portion of hospital expense will be paid by Medicare. Events now requires we do the same with the Medicare funding for the direct and indirect expenses for graduate medical education and other clinical training activities. The hearing today is a first step in that process.

Let me share with you several reasons why I believe the direct graduate medical education pass-through, as we now know it, will be eliminated within 2 years, and the indirect adjustment for medical education expenses will require refinement.

First, the pressure to reduce the Federal deficit combined with the impending bankruptcy of the Medicare trust fund demand and end to these types of open-ended subsidies. There are only three ways to reduce the costs of Medicare to the Federal Treasury. These are to reduce payments for Medicare services to providers, to increase cost sharing for Medicare beneficiaries, and to increase taxes for all of us. I assure you, before additional cost sharing is considered, the beneficiaries will place great pressure on the Congress to eliminate subsidies paid both under part A and part B to providers.

It is worth noting that Medicare covers only half of the total health care costs of the elderly and disabled, and we know from members of the Council of Teaching Hospitals, the group of the largest teaching hospitals, that 70 percent of the support for the direct costs of residents came from patient care revenues. These two figures will not be lost on these involved as the debate over cut-backs begins to intensify.

Second, traditionally, third-party payors have been willing to include graduate medical education as justified expense in paying teaching hospitals. At the same time, though, insurance plans placed no significant incentives for patients to seek or use lower cost medical facilities. Both these factors are changing in the current environment.

In a competitive marketplace, third party payors and alternative delivery systems are less willing to pay for graduate medical education and are steering plan members away from the more expensive teaching institutions.

These trends were illustrated for me at a recent conference I attended in Minneapolis on the financing of graduate medical education. As one attendee, who heads a major HMO in the Twin Cities put it, "They (the HMO's) want to purchase only those services which directly benefit their patients." It was obvious from his re-

marks and others we heard that the new environment is not supportive of the status quo for graduate medical education or teaching hospitals.

It is important to stress in the developing health care environment, that it is not only the HMO's and PPO's which will be placing the squeeze on teaching institutions. The consumer will begin to be player, also. To cut costs, employers are now increaseing cost sharing for employees. This trend is likely to speed up as efforts in the Congress contrive next year to cap the burgeoning tax subsidies, now over $30 billion provided for employee paid health insurance. As more of the costs of services are covered by individuals, they will be less prone to seek the services of high cost teaching institutions.

All of this is not to say that either physician training or the unique set of tertiary services provided by teaching hospitals is unnecessary. However, it does reflect the fact that Americans are going to be less willing to pay for either of these activities from their premium dollar. Therefore, we now have a tough set of questions to answer—who will take responsibility for graduate medical education, and how much will we pay for it?

Third, as we learned last Friday from our hearing, we have as of yet failed to resolve the tough question of "responsibility" for our indigent health care problem. It was pointed out at the hearing that the courts are beginning to settle this issue for us. But, I feel strongly it is the Congress together with the other governmental units which must take the "responsibility" and set explicit policies to assure access to quality and cost-effective care for all Americans.

The solution to financing care for the poor will greatly affect teaching hospitals and the financing of graduate medical education. It should not be assumed as a given that as financing mechanisms are arranged to fund the health care of the poor that they will either be encouraged or choose to seek care in teaching hospitals.

The Association of American Medical Colleges (AAMC) in its testimony on Friday pointed out that the nonfederal Council of Teaching Hospital members incur 35 percent of the bad debts and 47 percent of the charity care for the Nation's community hospitals. This level of commitment is laudable but it also fits with the need for many of the institutions to have teaching material for their student physicians. I have concerns about the provision of care for the poor and whether or not the teaching hospital is the best environment for them to receive necessary services.

We heard on Friday from Dr. Janelle Goetcheus that the care in teaching hospitals—at least for the poor—lacks continuity and is depersonalized. Evidence indicates it is also more costly. Today we should learn more about these issues.

Fourth, the deficit crunch we face next year will cause the Congress to reexamine current Federal priorities. Many cuts are likely, and this may mean reductions in the Federal funding for undergraduate and graduate medical education.

This process may include such "sacred cows" as the Veterans' Administration health expenditures. Currently, the Veterans' Administration hospital system has 8,000 full-time equivalent residency slots and 77 percent of the 172 VA hospitals have affiliation with medical schools. This significant commitment needs to be evaluated in light of the health needs of an aging veterans population as well as the constraints we face on Federal appropriations. Limited Veterans' Administration appropriations must be spent for the good of the beneficiaries first.

Along the same lines, the Federal commitment to funding training of the health profession must also always be scrutinized. This year, Title VII of the Public Health Services Act is likely to be reauthorized at levels above the 1984 budget. The authorizations are moderate but will need to be revisited next year as we consider overall new policies on the financing of graduate medical education.

Fifth, I believe there is a growing concern about equity and fairness across our health care system. We see this concern to some extent between urban and rural areas in the determination of prospective payment rates for Medicare. It may become further exacerbated by the Medicare waivers under which high cost States have adopted status quo-oriented all-payor systems. Under these waivers, the high cost of graduate medical education and care for the economically disadvantaged is locked in for all payors including Medicare.

It is not fair that the cost shift we have experienced in the past to fund graduate medical education and care for the poor be structured into the payment scheme for all-payors States while in others the pressure of competition ends this same shift. Instead, we should have explicit Government policies which enable appropriate funding for graduate education and the economically disadvantaged.

These are a few of the reasons we are here discussing medical education today. I see a growing consensus that the direct and indirect subsidies for medical education have helped produce a substantial surplus of physicians. This surplus has brought

with it inflated, economic returns to certain specialties without solving many of our problems of maldistributions of physicians by specialty and geography.

The issue of financing graduate medical education is definitely on the "front burner". The Department of Health and Human Services has contracted with Arthur Young to do a major analysis of graduate medical education costs. This study, due this fall, is late but we should begin to get preliminary results over the next 12 months. The Commonwealth Fund has commissioned a set of thought papers on graduate medical education and the cost of teaching hospitals. These papers should be completed early next year and will provide an important resource. Finally, and most importantly, the AAMC has appointed a committee to reexamine the policy of the academic medical community for financing graduate medical education. I look forward to the options which this committee will present.

The hearing today will provide us with important background on medical education. A second hearing will focus on medical education from the point of view of its various types of consumers or those who benefit; the students, the community hospitals, the teaching hospitals, and the patients. It will also examine the issue of physician distribution by specialty and location. A third hearing will examine options for establishing explicit responsibility for the financing of graduate medical education and other clinical training as well as define the federal role in the financing of these activities.

I appreciate our witnesses taking time to be with us today and look forward to learning from their testimony.

PAYMENTS FOR MEDICAL EDUCATION UNDER THE MEDICARE PROGRAM

INTRODUCTION

The Subcommittee on Health, Senate Committee on Finance, has scheduled a hearing on Monday, October 1, 1984, on the financing of medical education costs under the Medicare program. This document has been prepared to assist you in reviewing:

--The nature of health education activities and the role of teaching hospitals in medical education, including the associated costs and and current sources of financing;

--Medicare's historical and current policies for making payments to hospitals for the costs of education activities; and

--Key issues that have been raised concerning current and future financing for medical education activities.

BACKGROUND

Health education programs for the training of physicians, nurses and allied health personnel combine classroom training and learning through "hands on" experience. Classroom training is generally conducted in a university setting and the "hands on" or clinical training is generally hospital-based.

Contemporary medical education (the training of physicians) generally includes the completion of four years of medical school and a residency program lasting three years or more. Most of the undergraduate training of physicians is conducted in the classroom at the medical school. Clinical education at this stage is primarily in the form of hospital-based clerkships, which introduce students to clinical medicine in the various specialties. The traditional medical school curriculum requires third-year medical students to spend a fixed amount of time under the supervision of faculty and residents in the basic specialty areas which typically include internal medicine, surgery, obstetrics/gynecology, psychiatry, and pediatrics. The fourth-year student takes primarily elective clerkships, which provide either additional exposure to the basic specialties or introductions to other specialties.

Generally, the graduate education of physicians takes place in hospitals through residency programs, although a few residencies such as preventive medicine and occupational health are based primarily outside the hospital and family practice programs emphasize ambulatory care more than inpatient care.

Nursing education has evolved from what was once primarily three years of hospital-based training to several curricula which are becoming more closely

affiliated with or sponsored by colleges or universities. While the classroom training is now more likely to be in a college or university, hospitals remain the primary sites for the undergraduate clinical training of nurses, whether enrolled in associate or baccalaureate degree or hospital-based diploma programs.

Training for most allied health occupations (e.g., dietitians, physical therapists, speech pathologists, laboratory technicians, etc.) follows the same general model: two or more years of classroom training in a university or specialty school, followed by practical training in the hospital.

The principal focus of this background paper will be graduate medical education (the training of physicians in hospital residency programs) because the overwhelming majority of the costs of health education activities in hospitals are accounted for by such programs. In addition, very little data exist on the costs to hospitals of nursing and allied health programs.

Discussion of Medical Education in Hospitals

Characteristics of Teaching Hospitals

Clinical training for both undergraduate and graduate health manpower education in this country is generally conducted in the hospital setting. However, only a minority of hospitals offer teaching programs and those that do vary considerably in terms of the size and diversity of their teaching programs. Teaching hospitals may have programs for the training of physicians (generally called graduate medical education, conducted through residency programs), nurses, or such allied health personnel as dietitians, emergency medical technicians, occupational therapists, and physical therapists.

Hospitals and medical schools have developed several different relationships for the conduct of graduate medical education. At one extreme, a free-standing residency program may be established, staffed, and controlled by an individual hospital. At the other extreme, a residency program may be offered by a medical school through one or more "affiliated" hospitals. Between these extremes is a variety of hospital-medical school relationships.

The number of teaching hospitals in this country varies depending on the definition of teaching hospital used. Approximately 1,300 hospitals (18 percent) participate in at least one residency program. Over 1,000 of these hospitals are affiliated with medical schools. Approximately 400 of these teaching hospitals meet the requirements for membership in the Council of Teaching Hospitals (COTH) of the Association of American Medical Colleges, which include sponsorship of at least four approved residency programs 1/ and recommendation for membership by an accredited medical school with which the hospital is affiliated. Although data gathered by COTH from its members focuses on hospitals with major teaching programs and understates the number and variety of teaching hospitals in the country, little other data about teaching hospitals exist.

Major teaching hospitals are generally committed to at least three distinct objectives: providing patient care, training health professionals, and conducting clinical research. The interrelationship of these three activities within the teaching hospital creates an institution which is in many ways different from the single purpose non-teaching hospital. This interrelationship also makes it difficult to separate the activities and costs of medical education in a teaching hospital from its other activities, particularly patient care.

1/ That is, those accredited by the Accreditation Council for Graduate Medical Education or by the Residency Review Committee for the specific clinical specialty.

According to 1980 Council of Teaching Hospitals (COTH) data on its member hospitals, major teaching hospitals had the following characteristics: they were sponsored by non-profit corporations, they were disproportionately concentrated in the Northeast region of the country, over 75 percent were located in metropolitan areas having at least a half million population, they were generally large hospitals (75 percent had over 400 beds), and on average they employed over five times the number of full-time equivalent personnel employed in non-member hospitals.

In terms of service characteristics, teaching hospitals provided a wide range of hospital services, many of which (such as burn care units, organ banks, and open heart surgery) are typically unavailable in nonteaching community hospitals. Teaching hospitals also cared for a large number of poor persons (COTH members had 19 percent of the Nation's short stay beds but 25 percent of the medicaid admissions) and had an above average share of patient bad debt and charity care (bad debt and charity care were 9.4 percent of patient revenues in COTH member hospitals compared to 5.1 percent in non-COTH hospitals).

Measuring the Cost of Medical Education in Hospitals

Teaching hospitals incur certain direct and indirect costs resulting from their educational activities. The direct costs (those directly related to the teaching activity) include salaries and fringe benefits for faculty, residents and interns, and support staff; conference and classroom space within the hospital (together with any overhead costs for maintenance and utilities); and additional equipment and supplies. These direct costs are generally identifiable and separable by accounting methods from the costs of patient care in the hospital. The easiest educational costs to identify are the stipends and benefits paid to graduate medical education trainees (interns and residents). The

average amount that a COTH member hospital spent on resident stipends and benefits in 1982-1983 was $3.2 million, or approximately 5 percent of the average teaching hospital's total budget.

In addition to the direct costs of medical education, the presence of teaching activities can indirectly affect a hospital's costs. These indirect costs can arise from reduced productivity in patient service departments (e.g., treatment takes longer, demands on other staff are greater), increased overhead for such activities as the keeping of medical records, increased complexity of hospital management, and the tendency of residents to provide more services and to conduct more tests than are strictly necessary for patient care alone.

It is very difficult to separate out and quantify the indirect costs of medical education in teaching hospitals because patients are being treated and students are being trained through the same patient care activities. Costs for inpatient care or for particular services are generally higher in teaching hospitals than in non-teaching hospitals. Simple cost comparisons, for example, show that in 1981, the average cost of care in COTH hospitals was $3,281 per adjusted admission, nearly twice as high as the average of $1,683 in non-teaching hospitals, for a difference of $1,598 per adjusted admission. Based on these averages, if direct costs of medical education account for roughly 5 percent of total costs in teaching hospitals, then direct teaching costs cannot explain more than 10 percent of the difference in overall costs per unit. However, these simple cost comparisons do not answer the question of how much of the remaining difference is due to the indirect costs of teaching or to other factors such as a case load which includes sicker patients, more elaborate and expensive medical technology, higher prices for labor and supplies, or perhaps less efficient operation. Thus, although studies have been able to isolate the direct costs of

teaching activity, the indirect cost of teaching activity has proven difficult to estimate with precision.

Some studies have suggested that indirect costs may be quite large. For example, in a 1983 pilot study conducted by Arthur Young and Policy Analysis, Inc., total costs per admission (excluding direct costs of medical education) were analyzed for individual patients in four Diagnosis Related Groups (two medical and two surgical categories) for seven teaching and two non-teaching hospitals. The analysis indicated that, on average, total costs per admission were more than 60 percent higher in the teaching hospitals than in the non-teaching hospitals. Most of the observed difference in cost was attributed to differences in the use of ancillary tests and procedures. Further analysis of a subset of patients for whom severity of illness had been measured indicated, however, that some portion (but not all) of the difference may be attributable to differences in severity of illness. Other studies have shown a wide range of results. Some are roughly comparable to the Arthur Young study while others show almost no difference due to teaching activity (after controlling for severity of illness differences). Due to the limitations of the available studies, however, the size of indirect costs remains unclear.

Sources of Financing for Health Education

Patient care revenues are the primary source of support for both patient care and education programs in teaching hospitals. For example, according to the 1983 COTH Survey of House Staff Stipends, Benefits, and Funding, patient care revenues (including medicare's payments) provided 70 percent of the support for the direct costs of resident stipends and benefits. Other sources included the Veterans Administration (17 percent); State appropriations (5 percent); medical schools (2 percent); municipal appropriations (1 percent); and other

sources including physician fees, NIH, Federal agencies, grants and volunteers, and endowments (5 percent).

In recent years, questions have been raised concerning the desirability of using patient care revenues to support hospital-based clinical education. The third-party payers for medical care (for example, medicare, medicaid, Blue Cross, and commercial insurers) have been under tremendous pressure to control rising health care expenditures. Although the medicare program is currently committed to paying for medical education costs in connection with its payments for patient care, other third-party payers do not necessarily have such commitments. Some State medicaid programs and some Blue Cross plans disallow or discount certain educational expenses (such as resident stipends or teaching physicians' salaries) when reimbursing hospitals for patient care.

In addition to direct medical education support to hospitals through patient care revenues, the Federal Government also provides financial support for health education through grants to medical and nursing schools and direct student assistance in the form of loans, loan guarantees, and scholarships. Within the Department of Health and Human Services, such support includes programs for Health Professions Education (Title VII of the Public Health Service Act), Nurse Training (Title VIII of the Public Health Service Act), and the National Health Service Corps (NHSC) and NHSC Scholarship program.

Health Professions Education

Title VII of the Public Health Service Act authorizes Federal support for health professions education at schools of medicine, osteopathy, dentistry, veterinary medicine, optometry, podiatry, pharmacy, public health, and for programs of health care administration. Under this authority, two

kinds of assistance have been provided—institutional support for health professions schools and student assistance in the form of loans, loan guarantees, and scholarships for students enrolled at these schools. For the past several years, observers have noted the success which these programs have had in increasing enrollments at health professions schools, in increasing the supply of health professionals providing care in the Nation, and in improving the geographic distribution of health personnel throughout the country. As a result of this success, and forecasts that the Nation will have a surplus of physicians in the near future, aggregate funding for title VII programs has decreased in recent years. In addition, available Federal support has been redirected away from general subsidies for the training of physicians and other health professionals (capitation grants) awarded to schools on the basis of the number of students enrolled at schools, and targeted toward educational programs which are intended to address specific problems such as the geographic and specialty maldistribution of health personnel. The FY 1984 budget level for this program is $129 million.

Nurse Training

Nurse training programs authorized under title VIII of the Public Health Service Act have provided Federal support for nursing schools and students since 1964. Congress consolidated and expanded programs of nursing support in response to perceived shortages of professional nurses in the country. The nurse training authority of title VIII has provided institutional support for nursing schools and financial assistance for nursing students. Since the establishment of title VIII authority, the supply of registered nurses has increased from 550,000 to about 1,600,000. Maintaining that these increases have resulted in a current and projected supply adequate to meet nationwide health

care needs, recent administrations have sought to reduce Federal support for nurse training. FY 1984 funding for nurse training programs is $42 million.

National Health Service Corps

In 1972, P.L. 92-585 authorized the National Health Service Corps (NHSC) to be staffed by officers of the Public Health Service and other personnel as required by the Secretary of Health and Human Services. The Corps was established to provide health care services to persons residing in health manpower shortage areas through the placement in these areas of health professionals and health care resources. As of December 31, 1983, DHHS had designated 2,180 primary health care shortage areas, 987 dental shortage areas, and 273 vision care shortage areas. P.L. 92-585 also established a NHSC scholarship program to obtain health professionals for placement in health manpower shortage areas. Under this program, health professions students agree to serve in a health manpower shortage area in return for scholarship and stipend support. The scholarship recipient is required to fulfill his service obligation through the full-time clinical practice of his profession either as a commissioned officer in the Regular or Reserve Corps of the Public Health Service (after a finding that he or she is qualified) or as a civilian member of the Corps, or, at the discretion of the individual, in private practice in a designated health manpower shortage area. The FY 1984 budget includes $91 million for the NHSC and $6.3 million for NHSC scholarships.

Medicare's Payments for Medical Education Costs in Hospitals

Since its inception, the medicare program has recognized in its principles of cost reimbursement certain expenses associated with the operation of approved medical education programs in hospitals. Although not required by law, congressional intent indicated that the medicare program should pay its share of the net cost of education activities conducted in hospitals until the community undertakes to cover these costs in some other way:

> Many hospitals engage in substantial educational activities, including the training of medical students, internship and residency programs, the training of nurses, and the training of various paramedical personnel. Educational activities enhance the quality of care in an institution, and it is intended, until the community undertakes to bear such education costs in some other way, that a part of the net cost of such activities (including stipends of trainees as well as compensation of teachers and other costs) should be considered as an element in the cost of patient care, to be borne to an appropriate extent by the hospital insurance program. 2/

Medicare regulations (CFR, Title 42, Sec. 405.421) indicate that a provider's (e.g., a hospital's) allowable costs for purposes of medicare reimbursement may include the net cost of approved educational activities. Net cost is defined as a provider's total direct and overhead costs of approved educational activities (including trainee stipends, compensation of teachers, and other direct and overhead costs), minus revenues the provider receives from tuition and from grants and donations designated for the educational activities. However, for cost reporting periods beginning on or after January 1, 1978, grants

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2/ U.S. Congress. Senate. Social Security Amendments of 1965. Report of the Committee on Finance to Accompany H.R. 6675 to Provide a Hospital Insurance Program for the Aged . . . June 30, 1965. Washington, U.S. Govt. Print. Off., 1965. (89th Cong., 1st Sess. Senate Rept. No. 404, Part 2), p. 36.

and donations designated for internship and residency programs in family medicine, general internal medicine, and general pediatrics are not deducted in calculating net costs.

Approved education activities are defined by regulation as formally organized or planned programs of study usually engaged in by providers in order to enhance the quality of patient care in an institution. These activities must be licensed where required by State law; where licensing is not required, the institution must receive approval from the recognized national professional organization for the particular activity. Approved programs include medical, osteopathic, dental, and podiatry internships and residency programs and recognized nursing and allied health education and training programs which include: cytotechnology, dietetic internships, hospital administration residencies, inhalation therapy, medical records, medical technology, nurse anesthetists, professional nursing, practical nursing, occupational therapy, pharmacy residencies, physical therapy, and x-ray technology.

Payment Under Cost-Based Reimbursement

When the medicare program began in 1966, medicare paid for its proportional share of a hospital's direct medical education costs together with other allowable costs under medicare's cost-based method of reimbursement. Over the years, as the medicare program began to establish limits on the amounts it paid to hospitals, the costs of medical education received special consideration.

Under authority contained in Section 223 of the Social Security Amendments of 1972, the Department of Health, Education and Welfare began in 1974 to establish annual cost limits on reimbursement of certain routine hospital operating costs. The higher costs of hospitals with significant medical education activities were recognized by the medicare program in the late 1970s when an exception

to these hospital cost limits was allowed for hospitals whose costs of education activities exceeded the norm.

Explicit allowance was made for medical education costs, effective with hospital cost reporting periods which began July 1, 1979, when the direct costs of approved medical education programs were excluded from the costs subject to the medicare hospital costs limits. The direct medical education costs were excluded so that the basis on which the cost limits were applied in teaching and non-teaching hospitals would be comparable.

On April 1, 1980, the Department proposed that a new adjustment for the indirect costs of medical education programs be made to medicare's hospital cost limits. The proposed regulations stated that:

> Generally, hospitals with approved graduate medical education programs incur higher per diem operating costs than non-teaching hospitals of similar bed size and geographic location . . . . We believe these increases in per diem cost occur because the provision of graduate medical education causes increases in certain types of costs that are only indirectly related to education programs. . . . To prevent a disproportionate number of teaching hospitals from being adversely affected by the limits, we have, in the proposed schedule, provided an automatic adjustment for the costs generated by approved medical education programs. Based on the data we used to derive the proposed limits, we have estimated that a hospital's general inpatient routine operating costs may be expected to increase by a factor of .047 (4.7 percent) for each increase of .1 (above zero) in the ratio of its full-time equivalent (FTE) interns and residents (in approved programs) to its number of beds. 3/

It should be noted that the proposed regulations stated that to obtain this adjustment, a teaching hospital would not be required to identify explicitly the costs for which the adjustment was being made. Instead, the hospital would be required to report only its number of full-time equivalent interns and residents in approved programs which, together with the hospital's bed size, would be used to compute the percentage by which the hospital's reimbursement

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3/ Federal Register, April 1, 1980, p. 21584.

limit would be increased. This medical education adjustment, which later became known as the indirect medical education adjustment, became effective for hospital cost reporting periods which began on July 1, 1980.

The Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248, known as TEFRA) made certain changes in the hospital cost limits, including expansion of the limits to cover total inpatient operating costs (not just routine costs) so that ancillary and special care unit costs were now included under the limits. Because of this change, the hospital cost limits which DHHS established effective for hospital cost reporting periods beginning on October 1, 1982, included an increase in the percentage amount of the indirect medical education adjustment from 4.7 percent to 6.06 percent.

TEFRA also created a new ceiling on the allowable annual rate of increase in operating costs per case for inpatient hospital services. As with the hospital cost limits, the hospital costs subject to these new rate-of-increase limits excluded the direct costs of approved health education programs.

Payment Under the Prospective Payment System

Title VI of the Social Security Amendments of 1983 (P.L. 98-21) established a new method of hospital payment by the medicare program, known as the Prospective Payment System (PPS). Effective for hospital cost reporting periods that began October 1, 1983, the medicare program has been paying hospitals, with certain exceptions, according to predetermined rates for each of 468 Diagnosis Related Groups (DRGs), rather than on a cost basis. The prospective payment legislation and regulations, however, continue to provide for special treatment of direct and indirect medical education costs.

Direct Medical Education Costs Under PPS

The direct costs of medical education in hospitals are excluded by law from the prospective payment system and are paid for separately on the basis of reasonable costs. In its December 1982 report to Congress proposing a hospital prospective payment system for medicare, the Department favored excluding the direct costs of approved medical education programs from the prospective rates and reimbursing them on the basis of reasonable costs. As stated in the report: "This approach will assure that the base rate is related to a patient care outcome and not significantly influenced by factors whose existence is really based on objectives quite apart from the care of particular patients in a particular hospital. This approach will allow for continued Federal support of medical education through the medicare program while clearly identifying that support as separate from patient care." 4/

Indirect Medical Education Costs Under PPS

P.L. 98-21 requires that additional payments be made to hospitals for the indirect costs of medical education, computed in the same manner as the adjustment for indirect medical education costs was calculated under the medicare hospital cost limits, except that the educational adjustment factor would be doubled. The Report of the Finance Committee on the Social Security Act Amendments of 1983 indicates that the adjustment for indirect medical education costs is only a proxy to account for a number of factors which may legitimately increase costs in teaching institutions. The Report also states:

4/ U.S. Department of Health and Human Services. Report to Congress. Hospital Prospective Payment for Medicare. Dec. 1982. pp. 47-48.

> This adjustment is provided in the light of doubts (explicitly acknowledged by the Secretary in his recent report to Congress on prospective payment) about the ability of the DRG case classification system to account fully for factors such as severity of illness of patients requiring the specialized services and treatment programs provided by teaching institutions and the additional costs associated with the teaching of residents. The latter costs are understood to include the additional tests and procedures ordered by residents as well as the extra demands placed on other staff as they participate in the education process.
>
> The committee emphasizes its views that these indirect teaching expenses are not to be subjected to the same standards of "efficiency" implied under the DRG prospective system, but rather that they are legitimate expenses involved in the postgraduate medical education of physicians which the medicare program has historically recognized as worthy of support under the reimbursement system. 5/

As provided in medicare regulations, the indirect medical education payment equals 11.59 percent of the aggregate payment to a hospital from the Federal portion of its prospective payments for each 0.1 increment in the hospital's ratio of full-time equivalent (FTE) interns and residents to its bed size. Regulations define the number of FTE interns and residents to be the sum of the number of interns and residents employed for 35 hours or more per week, plus one-half of the number of interns and residents working less than 35 hours per week. As required by the Deficit Reduction Act of 1984 (P.L. 98-369), for cost reporting periods beginning on or after October 1, 1984, interns and residents are not required to be employees of the hospital in order for the hospital to qualify for the indirect medical education adjustment.

5/ U.S. Congress. Senate. Social Security Amendments of 1983. Report to Accompany S. 1. March 11, 1983. Washington, U.S. Govt. Print. Off., 1983. (98th Congress, 1st Session. Senate Rept. No. 98-23), p. 52.

Other Provisions for Teaching Hospitals Under PPS

In addition to the explicit provisions in the prospective payment legislation for direct and indirect medical education costs, provisions relating to payments for atypical cases also benefit teaching hospitals. Both the Finance and the Ways and Means Reports indicate that the provision of additional payments for atypical cases which have either extremely long lengths of stay or extraordinarily high costs (known as "outliers") would benefit teaching hospitals since the committees believed it reasonable to expect that such cases would occur more commonly in teaching hospitals than in other hospitals.

Cost to Medicare for Medical Education in Hospitals

The Report of the 1982 Advisory Council on Social Security (December 31, 1982) states that historically, expenditures for the education and training of health professionals have represented between 4 and 6 percent of annual medicare Health Insurance (HI) Trust Fund expenditures. The Report indicates that in 1980 the HI trust fund spent an estimated $1.4 billion for the direct and indirect costs of medical education programs; for 1983, the estimate is $1.8 billion; for 1987, $2.8 billion is estimated.

ISSUES

A number of key issues have been identified in response to the current policy and payment methods for medical education adopted in the medicare hospital prospective payment system (PPS). In addition, broader questions have been raised about the potential impact on medical education in hospitals of certain system-wide changes in financing and delivery of medical care. These issues are briefly described and discussed below.

Should Medicare Pay for Medical Education Costs?

Questions have been raised whether the medicare program, which was designed to pay for medical services to medicare beneficiaries, should continue to underwrite the cost of medical education through its payments to hospitals. In view of the financial crisis facing the medicare program, some (for example, the 1982 Advisory Council on Social Security) have recommended that medicare's support for medical training be withdrawn as other sources of support are identified. Others have argued that medicare's Hospital Insurance trust fund is an inappropriate source of medical education subsidy because those who benefit (primarily doctors) will generally earn incomes much higher than the employees who pay the medicare payroll tax. Still others question whether medicare should continue to make money available for medical education when there appears to be an adequate supply of physicians and other health care professionals except in a few areas of targeted Federal support, such as primary care. Finally, some critics have noted that financial support for medical education cannot be efficiently targeted as long as it remains embedded in payments for patient care.

Those who favor continuing medicare's support for medical education fear that if medicare were to limit or completely withdraw such support, the training of health professionals and the provision of patient care in hospitals

would both suffer. These problems could be intensified if other third-party payers were to follow medicare's lead in eliminating support for medical education. Another problem is whether other Federal, State or local sources of support for medical education could be found to replace medicare's payments if they were withdrawn. Also, if medicare were to eliminate payments for medical education, some argue that additional medicare dollars might be required to pay for physicians' services needed to replace the care currently provided by interns and residents.

Incentive Effects of Current Medicare Policy

As required by law, under the medicare PPS system, payments for the indirect costs of medical education activity are based on a teaching adjustment factor which is twice as large as the estimated amount required to cover these costs (11.59 percent instead of 5.795 percent). As a result, some observers argue that residents and residency programs now generate more income for the hospital than they cost. In addition, the extra payment for indirect costs of medical education is the same for each additional resident regardless of which specialty or year of residency is involved. Since the resource demands made by residents vary with the area of clinical specialization (e.g., surgery, pediatrics, pathology, etc.) and the experience of the resident (year of training), some residency programs are believed to be much more profitable than others. Thus, some observers argue that current policy creates incentives for hospitals to provide more medical education (i.e., train more physicians) and to train a different mix of physician specialties than would be consistent with societal needs (e.g., too many general surgeons and not enough internists). Others point out also that the policy of making essentially unrestricted payments for graduate medical education activities of hospitals conflicts with other Fe

health personnel training policies (under title VII of the Public Health Service Act) which limit Federal support to areas in which a national need is perceived.

Payments for Higher Costs of Teaching Hospitals

The medicare program is currently making additional payments to teaching hospitals for: (1) the direct costs of medical education activities and (2) any additional costs which teaching hospitals incur either indirectly from their teaching activities or perhaps from other factors which are not exclusively found in teaching hospitals, such as their more complex patient case mix or their role in the introduction and use of the latest and most expensive technologies.

Should the medicare program make additional payments for the higher costs of teaching hospitals, even if those costs are not necessarily related to teaching activities? If so, is the indirect teaching adjustment formula, which uses a measure of direct teaching activity (interns and residents per bed) as a proxy for indirect costs, a suitable way of paying for higher costs in teaching hospitals? A goal of the prospective payment system is to encourage efficient hospital behavior by paying a fixed price for hospital services according to patient diagnosis. Is the medicare program paying for inefficiencies in teaching hospitals through the indirect teaching adjustment? How can the medicare program determine if its payments to teaching hospitals are adequate or too generous?

Effects of Reimbursement Changes and Competition

Patient care revenues have been the primary source of support for educational programs in teaching hospitals. In the past, when hospitals were paid

whatever their costs or charges were, neither the costs of their medical education programs nor the costs of teaching hospitals relative to non-teaching hospitals were perceived to be a problem. Recently, in order to decrease their expenditures for hospital care, many third-party payers have changed their methods of reimbursing hospitals for care provided to their beneficiaries. Much of the reimbursement focus is on the price the payer is willing to pay for hospital services, rather than the cost to the hospital of providing the services. If the payer determines that the price should include nothing more than the cost of patient care, then teaching hospitals, with their additional costs attributable to their teaching programs, may be at a disadvantage both in terms of the adequacy of the revenues they receive and their ability to compete with non-teaching hospitals. Hospital responses to shortfalls in reimbursement are generally to charge more or to alter or eliminate services, either of which could put teaching hospitals at an even greater disadvantage competitively. The elimination of services and activities which bring inadequate reimbursement to the teaching hospital could also run counter to public policy if such services are deemed important.

Locus of Medical Education Training

Most of the graduate medical education in this country is being conducted in the inpatient hospital setting. However, a trend presently exists to provide patient care in a less costly ambulatory care setting. If this trend continues, more medical education than at present may need to be conducted in an ambulatory care setting. Under these circumstances, some suggest that a certain amount of payments for medical education should be made to ambulatory care settings instead of hospitals.

Senator DURENBERGER. The hearing will come to order.

It's 2 p.m., regardless of what the clock says.

I have a rather lengthy opening statement, and then we have a problem this afternoon in that the Senate isn't sure what it wants to do between now and the election. So there will be at least one more vote during the course of the afternoon which will necessitate my briefly recessing this hearing.

The net implication of all that may be to limit—I really don't want to put a crimp in the testimony of any of the witnesses—some of the questions from the Chair and the submission of those questions in writing. So just to alert all of you that there will be several coffee breaks during the course of the afternoon.

Let me start by trying to put what we are doing today in context. Let me put it first in the context of the 1965 enactment that brought us the Medicare Program. As it relates to education, "educational activities," I'm quoting the law, "enhance the quality of care in an institution and it is intended until the community undertakes to bear such education costs in some other way, that a part of the net cost of such activities, including stipends of trainees as well as compensation of teachers and other costs, should be considered as an element in the cost of patient care to be borne to an appropriate extent by the hospital insurance program."

That, I understand, still to be current law. The Social Security Act Amendments of 1983 provided for a radical reform in the payment of hospitals under part A of the Medicare Program. The new prospective payment system mandated by the act was designed to phase in over a 3-year period. By the end of the phase-in, the Medicare rates for hospitals will be set according to a national average payment per diagnosis related grouping. In recognization of the disparite locations and service and training mix for hospitals, the Congress provided under the new scheme for urban and rural variations and payments, passthroughs for hospital-incurred capital costs, passthrough for the direct cost allocated with graduate medical education and other clinical training activities.

An additional adjustment was allowed for the indirect cost of graduate medical education incurred by teaching hospitals. The adjustment for indirect medical education reflected such things as a sicker patient load, expensive medical technological capacities, costs allocated to training residents, the insensitivity of the present DRG system to severity of illness and similar factors.

As improved methods of establishing severity are devised, these developments will be incorporated into the overall DRG payment system. These refinements will make some portion of this indirect expense unnecessary. The remainder of the adjustment, based on broad assumptions about the nature of teaching hospitals, also requires close scrutiny.

Congress has set the end of the phase-in period for the prospective payment system for hospitals 2 years from today as the deadline for setting in place the new methodology under which the capital portion of hospital expenses will be paid by Medicare. We must consider that events between now and then may require us to do the same with regard to the current legislative mandate for Medicare funding of direct and indirect expenses, for graduate medical education, and other clinical training activities.

The hearing today is a first step in addressing that potential.

Let me share with you several concerns that I have; reasons, I suppose, why I am coming to the conclusion that direct graduate medical education passthroughs, as we now know them, may be eliminated within 2 years, and the indirect adjustment for medical education expenses refined.

First, the pressure to reduce the Federal deficit, combined with the impending bankruptcy of the Medicare Trust Fund, demands an end to open-ended subsidies. We need look no farther than the Advisory Council on Social Security and their recommendations in this regard.

There are only three ways to reduce the cost of Medicare to the Federal Treasury. These are to reduce payments of Medicare services to providers, to increase cost sharing for Medicare beneficiaries and/or to increase taxes for all of us.

I assure you before additional cost sharing is considered, those who are beneficiaries of the Medicare Program—and they are already doing it—will place great political pressure on the Congress to eliminate subsidies paid both under part A and part B to providers.

It is worth noting that the elderly and disabled in this country who use Medicare pay approximately 50 percent of the cost of the services rendered. At least that's what I hear on the floor from Teddy Kennedy every time we debate these issues.

And we know from the members of the council teaching hospitals, the groups of the largest teaching hospitals, that 70 percent of the support for the direct cost of residents in graduate medical education comes from patient care revenues.

These two figures will not be lost to those involved as the debate over cutbacks, deficits and spending reductions begins to intensify.

The second concern. Traditionally, third-party payers have been willing to include graduate medical education as a justified expense in paying teaching hospitals. At the same time, though, insurance plans place no significant incentives for patients to seek or use lower cost medical facilities. Both these factors are changing in the current environment.

In a competitive marketplace, third-party payers and alternative delivery systems are much less willing to pay for graduate medical education or any other subsidy, and are steering plan members away from the more expensive teaching institutions. These trends were illustrated for me at a recent conference in Minneapolis on the financing of graduate medical education. As one attendee who had the major HMO in the Twin Cities put it, and I will quote him, "They," referring to the HMO's, "want to purchase only those services which directly benefit their patients."

It was obvious from his remarks and others we heard from that the new environment is not supportive of the status quo for graduate medical education or teaching hospitals.

It is important to stress in the developing health care environment that it is not only the HMO's and PPO's which will be placing the squeeze on teaching institutions. The consumer will begin to be a player as well. To cut costs, employers are now increasing cost sharing for employees. This trend is likely to speed up as efforts in the Congress contrive next year to cap the burgeoning tax

subsidies now over $30 billion provided for employee paid health insurance.

As more of the costs of services are covered by individuals, they will be less prone to seek the services of high cost teaching institutions.

All of this is not to say that either physician training or the unique set of tertiary services provided by teaching hospitals is unnecessary. Quite to the contrary. However, it does reflect the fact that Americans are going to be less willing to pay for either of these activities from their premium dollar.

Therefore, we now have a tough set of questions to answer—who will take responsibility for graduate medical education? And how much will we pay for it?

Third reason. As we learned last Friday from our hearing on health care for the economically disadvantaged, we have, as of yet, failed to resolve the tough question of the responsibility for the indigent and their health care. It was pointed out at that hearing that the courts are beginning to settle the issue for us.

But I feel strongly it is the Congress, together with the other governmental units, which must take the responsibility and set explicit policies to assure access to quality and cost effective care for all Americans. The solution to financing care for the poor will greatly affect teaching hospitals in the financing of graduate medical education. It should not be assumed to the given that its financing mechanisms are arranged upon the health care of the poor. That they will either be encouraged or choose to seek care in teaching hospitals.

The Association of the American Medical Colleges in its testimony on Friday pointed out that the non-Federal council of teaching hospital members incur 35 percent of the bad debts and 47 percent of the charity care for the Nation's community hospitals. This level of commitment is laudible. But it also fits with the need for many of the institutions to have teaching material for their student physicians.

I have concerns about the provision of care for the poor and whether or not the teaching hospital is the best environment for them to receive necessary services. We heard on Friday from Dr. Janelle Goetcheus that the care in teaching hospitals, at least for the poor, lacks continuity, and is depersonalized. Evidence indicates it is also more costly.

Today we should learn more about these kinds of issues.

Fourth. The debt problem. The deficit crunch we face next year will cause the Congress to reexamine current Federal priorities. Many cuts are likely. And this may mean reductions in the Federal funding for undergraduate and graduate medical education. The process could include such sacred cows as the Veterans' Administration health expenditures. Currently, the VA hospital system has 8,000 full-time equivalent residency slots, and 77 percent of 172 VA hospitals have affiliations with medical schools. This significant commitment will be reevaluated in light of the changing health needs of an aging veterans population, as well as the constraints we face on appropriations.

Limited Veterans' Administration appropriations should be spent for the good of the beneficiaries first.

Along the same lines, the Federal commitment to funding training of the health profession must also be scrutinized. This year, title 7 of the Public Health Services Act is likely to be reauthorized at levels above the 1984 budget. The authorizations are moderate, but will need to be revisited next year, which is not an election year, as we consider overall new policies on the financing of graduate medical education.

And, fifth, I believe there's a growing concern about equity and fairness across our health care system. We see this concern, to some extent, between urban and rural areas in the determination of prospective payment rates for Medicare. It may become further exacerbated by the Medicare waivers under which high cost States have adopted status quo oriented all-payer systems.

Under these waivers, the high cost of graduate medical education and care for the economically disadvantaged is locked in for all payers, including Medicare.

It is not fair that the cost shift we have experienced in the past to fund graduate medical education and care for the poor be structured into the payment scheme for all payer States, while in other States, the pressure of competition ends the same shift.

Instead, we should have explicit Government policies which enable appropriate funding for graduate medical education and the economically disadvantaged. Otherwise, all graduate medical education will be financed in the high cost health care States with high cost graduate medical education.

These are a few of the reasons we are here discussing medical education today. I see a growing consensus that the direct and indirect subsidies for medical education have helped produce a substantial surplus of physicians. This surplus has brought with it inflated economic returns to certain specialties without solving many of our problems of maldistribution of physicians by specialty and by geography.

The issue of financing graduate medical education is definitely on the front burner. And I hope those of us who care about the future of medical education can keep it there.

The Department of Health and Human Services has contracted with Arthur Young to do a major analysis of graduate medical education costs. The study, due this fall, is late, but we should begin to get preliminary results over the next 12 months.

The Commonwealth Fund has commissioned a set of thought papers on graduate medical education and the cost of teaching hospitals. These papers should be completed early next year, and will provide an important resource.

Finally, and most importantly, the AAMC has appointed a committee to reexamine the policy of the academic medical community for financing graduate medical education.

I look forward to the options which this committee will present because I agree with the American Medical Association in the testimony that they will provide today that we not change the present system until a better replacement can be found. That's precisely why you see a very generous transition in the prospective payment system for teaching hospitals. It's precisely why you saw me fight with HHS on a more realistic reimbursement formula for hospitals.

But 2 years from today, things may be different.

The hearing today will provide us with important background on medical education.

In a second hearing, we intend to look at medical education from the standpoint of the consumers, community hospitals that need the specialized tertiary care provided by so many of our academic medical centers and their teaching hospitals. The professionals, the health care professionals, we will ask them about the quality, the cost and the appropriateness of today's medical education. And we will talk to consumers of health care and their representatives at the State-local government level and the private level about the quality and the availability of professional care.

Hopefully, our final hearings will examine options for establishing explicit responsibility for the financing of graduate medical education and other clinical training, as well as define the Federal role in the financing of these activities.

I appreciate our witnesses taking time to be with us today. I have read most of the statements, I think, and they are the education that all of us need. And all of those statements will be made a part of the record.

With that, I'm sure that's about the longest opening statement that I have made for any hearing. And the purpose of it was to partially scope the hearing and also to say that we are beginning today what I trust will be approximately a 2-year process, and that there will be conclusions at the end of that process.

I would judge from the testimony we have seen so far and the willingness of the entire community interested in this subject to not only demonstrate their concern but to work together to try to find some solutions; that this will be a very helpful process of interchange between all of us, because I think that better replacement is going to have to be found.

Our first panel consists of Dr. Henry Desmarais, the Director of the Bureau of Eligibility, Reimbursement and Coverage of HCFA; Dr. Robert Graham, Administrator of the Health Resources and Services Administration of the Public Health Service.

Let us begin with your testimony.

We are going to try for 5 minutes. If it takes a little longer, that's fine. As I indicated in the beginning, because of the nature of the afternoon, it may be that there are going to be limited questions from the Chair.

Why don't you proceed, Dr. Desmarais?

STATEMENT OF DR. HENRY DESMARAIS, DIRECTOR, BUREAU OF ELIGIBILITY, REIMBURSEMENT, AND COVERAGE OF THE HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY DR. ALLEN DOBSON

Dr. DESMARAIS. My name is Henry Desmarais, and with me is Dr. Allen Dobson, who is the Director of the Office of Research at the Health Care Financing Administration.

As you have requested, we are here to give you an overview of how Medicare currently reimburses hospitals for medical education costs. Traditionally, Medicare has paid its share of those costs, and that was all built on the historic precedents of Blue Cross.

The medical education story really has two chapters. And the first one is the direct medical education costs. Basically, it's a direct cost passthrough of all approved programs. And that includes things such as stipends of trainees, compensation of teachers, classroom costs, blackboards, et cetera, and associated overhead. And there are some accounting conventions and Medicare reimbursement principles that determine the amount of the cost passthrough that is reimbursed under the Medicare Program.

When the prospective payment system was proposed by the administration, we urged that this current arrangement of a direct passthrough for direct medical education costs be retained. And Congress did agree at that time.

The second part of the medical education story deals with the so-called indirect medical education costs. And this is based on an observation that had been made that costs in teaching hospitals were higher than costs in nonteaching hospitals. And the factor that was used to examine this was the intern-and-resident-to-bed ratio of hospitals. And it was observed that the higher that ratio, the higher the costs in that particular facility.

I might add that the exact cause and effect of that observation could not be deciphered based on the data available. There are those who feel there may be some case mix contribution; it may be the result of additional tests being ordered by inexperienced physicians or it may be the result of some kind of inefficiency. Nor was there a judgment about whether those costs were appropriate or inappropriate.

At any rate, based on these observations, for every 0.1 factor of interns and residents to bed, the cost limit per case allowed was 6.06 percent higher. This predates the prospective payment system.

These observations were taken into account as we advanced the prospective payment proposal, and again, the report to Congress recommended no change; that these indirect costs be recognized separately under the prospective payment system.

The Congress agreed with this. But I might point out the Congress chose to double the formula that had been used to calculate the indirect medical education adjustment. And when we did that, using the most current data available at that time, the double formula produces an 11.59-percent increase in the payments, Federal payments, under the prospective payment system. So it is 11.59 percent of both the PPS rate as well as the outlier payments, the Federal outlier payments, for every 0.1 percent increase in the ratio of the interns and residents to beds.

This is described as a lump sum payment, but it's probably more accurate to say that it's divided and paid under installments, which is more correctly known as "periodic interim payments."

The other thing that's important for us to talk about today is which interns and residents could be counted in coming up with this particular formula. Originally under the prospective payment system and the interim final regulation that was published, only those interns and residents actually employed by the hospital and providing services at the hospital were counted in coming up with the indirect payment amount. However, responding to criticism from various sectors that this was inequitable, in the January 1984 final regulation of prospective payment, we expanded this to in-

clude those interns and residents who were working at a hospital but were employed by another entity, which had had a long-standing, historic medical relationship with the hospital. I think a classic example there—very familiar to the chairman—is the Mayo Clinic. And that institution and those interns employed by that institution were then included for purposes of calculating the indirect payment amount.

Congress made further changes in the Deficit Reduction Act which was enacted this past July. And in that case, Congress directed that all interns and residents be counted if they were providing services. And there is no importance attached to who employed them or who paid their salary and so on.

Obviously, if we are going to count every intern and resident, no matter in which facility they work or how many hospitals they work in, we have to be very careful that we count them appropriately so that every intern and resident is only counted once. And we are prepared to monitor that situation and collect the data that is necessary in order to do that.

Let's move on and talk about the effects of all of these policies. Obviously, the prospective payment system was set up on a budget neutrality mode, and that clearly says that the more dollars which flow to one facility, whether that's a teaching or nonteaching facility, it means less dollars will flow to the other facilities.

We did a simulation which attempts to predict the effect of the current policy. And that simulation acted as if all hospitals receiving prospective payment amounts were paid at 100 percent of the Federal regional rate in year one of the prospective payment system. And, actually, only 25 percent of the payment amount was the Federal regional rate.

That simulation showed some very interesting findings. It showed that if you look at the 118 so-called heavy teaching hospitals, they would receive an average of $756 per case in direct medical education reimbursement. They would also receive an average of $2,158 per case for indirect medical education. And we would compare those amounts to the DRG payment of $4,079 per case.

There is a 53 percent add-on then to the DRG payment for indirect, and an additional $756 per case for direct medical education for those heavy teaching facilities. And we can compare that to the fact that the average direct and indirect payments for teaching hospitals, for those heavy teaching hospitals, would be the same as the DRG payment for non-teaching hospitals.

If you look at the other teaching facilities, about 654 of them, you find that the DRG payments for them per case is approximately $3,659. And they receive a 10-percent add-on for indirect medical education, and a further 6-percent add-on for direct medical education.

Backing away and looking at it globally, this means that, in budget neutral terms, about $204 per case must be shifted away from all hospitals receiving prospective payment reimbursement so that the teaching hospitals may receive an average of $613 per case for indirect medical education.

Wha about the future? Clearly, we intend to closely monitor the payments and attempt to suggest refinements where needed. The Department is also currently sponsoring a major study of the fi-

nancing and cost of graduate medical education and findings are expected in mid-1985.

And, finally, the Health Care Financing Administration is investigating the case mix measurement improvements to see if improvements over our current diagnosis related classification scheme are possible and whether, in fact, those case mix differences would explain some or all of the differences in the cost in teaching facilities. That work is very much underway.

This concludes my remarks. And I would be delighted to answer any questions.

Senator DURENBERGER. Thank you, Dr. Desmarais.

[The prepared written statement of Dr. Desmarais follows:]

DEPARTMENT OF HEALTH & HUMAN SERVICES

Washington DC 2...

STATEMENT OF

HENRY R. DESMARAIS, M.D.

DIRECTOR

BUREAU OF ELIGIBILITY, REIMBURSEMENT AND COVERAGE

HEALTH CARE FINANCING ADMINISTRATION

BEFORE THE

SUBCOMMITTEE ON HEALTH

COMMITTEE ON FINANCE

UNITED STATES SENATE

OCTOBER 1, 1984

I AM HENRY DESMARAIS, DIRECTOR OF THE HEALTH CARE FINANCING ADMINISTRATION'S (HCFA) BUREAU OF ELIGIBILITY, REIMBURSEMENT AND COVERAGE. ACCOMPANYING ME IS ALLEN DOBSON, DIRECTOR OF HCFA'S OFFICE OF RESEARCH. I AM PLEASED TO BE HERE TO PRESENT AN OVERVIEW OF HOW MEDICARE CURRENTLY REIMBURSES HOSPITALS FOR MEDICAL EDUCATION COSTS.

BACKGROUND

MANY HOSPITALS ENGAGE IN EDUCATIONAL ACTIVITIES, INCLUDING TRAINING PROGRAMS FOR MEDICAL STUDENTS, INTERNS, RESIDENTS, NURSES AND VARIOUS PARAMEDICAL SPECIALTIES. THESE PROGRAMS CONTRIBUTE TO THE QUALITY OF PATIENT CARE WITHIN THE INSTITUTION AND ARE NECESSARY TO MEET THE COMMUNITY'S NEEDS FOR MEDICAL AND PARAMEDICAL PERSONNEL. THE COMMITTEE REPORTS WHICH ACCOMPANIED THE PASSAGE OF THE MEDICARE PROGRAM IN 1965 RECOGNIZED THAT UNTIL THE COMMUNITY UNDERTAKES TO BEAR SUCH EDUCATION COSTS IN SOME OTHER WAY, A PART OF THE NET COST OF SUCH ACTIVITIES SHOULD BE CONSIDERED AS AN ELEMENT IN THE COST OF PATIENT CARE. FOLLOWING THIS DIRECTIVE, THE MEDICARE PRINCIPLES OF REASONABLE COST REIMBURSEMENT SPECIFICALLY INCLUDE MEDICAL EDUCATION COSTS.

THE ORIGINAL COMMITTEE REPORTS ALSO RECOMMENDED THAT WHEN DEVELOPING THE PRINCIPLES OF REIMBURSEMENT, MEDICARE SHOULD DRAW UPON THE EXPERIENCE OF PRIVATE ORGANIZATIONS. MEDICARE'S PRINCIPLES FOR SEPARATELY RECOGNIZING MEDICAL

EDUCATION COSTS WERE MODELED ON A LONG-STANDING COST REIMBURSEMENT PRINCIPLE USED BY BLUE CROSS AND OTHER PLANS IN REIMBURSING MEDICAL EDUCATION.

HISTORICALLY, MEDICARE EXPENDITURES FOR THE EDUCATION AND TRAINING OF HEALTH PROFESSIONALS HAVE REPRESENTED BETWEEN 4 AND 6 PERCENT OF ANNUAL HOSPITAL INSURANCE (HI) TRUST FUND EXPENDITURES.

WITH IMPLEMENTATION OF THE PROSPECTIVE PAYMENT SYSTEM BEGINNING IN FISCAL YEAR 1984, THE COST OF MEDICAL EDUCATION PROGRAMS IS EXPECTED TO GROW. THIS WILL RESULT BECAUSE DIRECT MEDICAL EDUCATION COSTS ARE PAID ON THE BASIS OF REASONABLE COSTS, AND AN ADDITIONAL SPECIAL ALLOWANCE, DOUBLE THAT PROVIDED UNDER THE PREVIOUS SYSTEM OF COST LIMITS, IS MADE FOR THE INDIRECT COSTS GENERATED BY INTERN AND RESIDENCY PROGRAMS. THEREFORE, THE SYSTEM CONTAINS NO DIRECT INCENTIVE TO RESTRAIN THE GROWTH OF MEDICAL EDUCATION COSTS.

Direct Medical Education Costs

THE TERM "MEDICAL EDUCATION COSTS" ENCOMPASSES NOT ONLY THOSE COSTS ASSOCIATED WITH PROGRAMS TRAINING PHYSICIANS BUT ALSO A RANGE OF HEALTH PROFESSIONAL AND PARAPROFESSIONAL TRAINING PROGRAMS. MEDICARE REGULATIONS SPECIFICALLY RECOGNIZE 13 APPROVED PROGRAMS IN ADDITION TO PHYSICIAN

TRAINING PROGRAMS, RANGING FROM NURSING AND CYTOTECHNOLOGY TO MEDICAL RECORDS TRAINING. CERTAIN ADDITIONAL PROGRAMS MAY ALSO BE INCLUDED.

DIRECT MEDICAL EDUCATION COSTS SUCH AS STIPENDS OF TRAINEES, COMPENSATION OF TEACHERS, AND CLASSROOM AND ASSOCIATED OVERHEAD ARE NORMALLY ALLOCATED TO SPECIAL COST CENTERS UNDER MEDICARE'S COST REPORTING SYSTEM. MEDICARE'S SHARE OF THESE COSTS IS DETERMINED USING THE SAME PROCEDURES THAT WERE DEVELOPED FOR COST-BASED REIMBURSEMENT TO ALLOCATE PATIENT CARE COSTS TO MEDICARE.

WHEN DEVELOPING ITS PROPOSAL FOR A PROSPECTIVE PAYMENT SYSTEM FOR HOSPITALS, THE DEPARTMENT OF HEALTH AND HUMAN SERVICES RECOMMENDED AND CONGRESS APPROVED CONTINUING TO PAY FOR DIRECT MEDICAL EDUCATION COSTS ON A COST-RELATED BASIS SEPARATE FROM THE DIAGNOSIS-RELATED GROUP (DRG) PAYMENT PER CASE. ALLOWANCE OF THIS PASS-THROUGH OF DIRECT MEDICAL EDUCATION COSTS RECOGNIZES THAT THE OPERATION OF MEDICAL EDUCATION PROGRAMS AND THE ACCOMPANYING COSTS ARE CONCENTRATED IN A LIMITED NUMBER OF HOSPITALS AND SUCH COSTS ARE GENERALLY NOT RELATED TO EFFICIENCY OF OPERATIONS. NEARLY 800 HOSPITALS COVERED BY THE PROSPECTIVE PAYMENT SYSTEM HAVE MEDICAL RESIDENCY PROGRAMS.

Indirect Medical Education Costs

The presence of medical education programs and their trainees also generates additional costs for support services and other activities which cannot be easily separated from patient care costs. The higher costs associated with teaching hospitals may include increased departmental overhead and the higher cost of treating patients due to increased laboratory tests and similar services. Some people believe that these higher costs may be due, in part, to greater complexity of cases not captured by our case-mix measure. Under the totally cost-based program, such costs were generally included in the department in which they were provided. Originally, there were virtually no limits on the amount of the costs that could be incurred and the actual placement of these costs on a cost report had little significance. However, when cost limits were placed on routine operating costs and later on costs per case, these indirect costs of medical education became significant since the limits were derived from groupings of many hospitals, many of which did not have teaching programs, leaving hospitals with indirect medical education costs at a disadvantage.

In 1980, a formula was developed to determine additional amounts which would be added to cost limits for teaching

HOSPITALS. THE FORMULA WAS A PERCENTAGE ADJUSTMENT BASED ON THE RATIO OF INTERNS AND RESIDENTS TO BEDS. THE PERCENTAGE IS DERIVED FROM AN ANALYSIS OF COSTS PER CASE AND THE PRESENCE OF INTERNS AND RESIDENTS IN THE HOSPITAL AND IS DESIGNED TO PROVIDE AN ALLOWANCE FOR THE HIGHER COSTS ASSOCIATED WITH TEACHING INSTITUTIONS.

UNDER THE COST LIMIT SYSTEM, THE PERCENTAGE ADJUSTMENT FOR INDIRECT MEDICAL EDUCATION COSTS RAISED THE LIMIT ABOVE WHICH COSTS WOULD NOT BE PAYABLE. HOSPITALS WITH COSTS BELOW THE COST LIMIT RECEIVED THEIR FULL COSTS WITHOUT ADDITIONAL PAYMENT TO FURTHER RECOGNIZE INDIRECT MEDICAL EDUCATION COSTS.

WHEN DEVELOPING THE PROSPECTIVE PAYMENT LEGISLATION, CONGRESS DETERMINED THAT AN AMOUNT SHOULD BE PAYABLE FOR INDIRECT MEDICAL EDUCATION COSTS IN ADDITION TO THE COST REIMBURSEMENT OF DIRECT MEDICAL EDUCATION COSTS AND THE OTHERWISE APPLICABLE PROSPECTIVE PAYMENT RATES. CONGRESS DOUBLED THE FORMULA THAT HAD BEEN USED TO DERIVE A PERCENTAGE INCREASE IN COST LIMITS SO THAT FOR COST REPORTING YEARS BEGINNING IN FISCAL YEARS 1984 AND 1985, THE INDIRECT MEDICAL EDUCATION ADJUSTMENT PROVIDES AN 11.59 PERCENT INCREASE IN THE FEDERAL PORTION OF THE PROSPECTIVE PAYMENT RATE FOR EVERY 0.1 PERCENT INCREASE (OVER ZERO) IN THE RATIO OF INTERNS AND RESIDENTS TO BEDS. THIS PERCENTAGE MAY BE ADJUSTED PERIODICALLY AS MORE CURRENT AND COMPLETE

DATA BECOME AVAILABLE. IN CONTRAST WITH THE ADJUSTMENT OF THE COST LIMITS, THE ADJUSTMENT FOR INDIRECT COSTS OF MEDICAL EDUCATION UNDER PROSPECTIVE PAYMENT IS AN ACTUAL ADDITIONAL PAYMENT TO TEACHING HOSPITALS WHICH IS DETERMINED RETROACTIVELY BASED ON THE TOTAL REVENUE FROM THE FEDERAL PORTION OF THE PROSPECTIVE PAYMENT RATE.

PRIOR TO JANUARY 1984, FOR PURPOSES OF THE RATIO, HOSPITALS COULD COUNT ONLY THOSE INTERNS AND RESIDENTS EMPLOYED BY AND PROVIDING SERVICES AT THE HOSPITAL. THIS METHOD OF COUNTING CONFORMED TO AMERICAN HOSPITAL ASSOCIATION SURVEY REQUIREMENTS. IN JANUARY, THE REGULATIONS WERE REVISED TO PERMIT A HOSPITAL TO ALSO INCLUDE INTERNS AND RESIDENTS EMPLOYED BY ANOTHER ORGANIZATION WITH WHICH IT HAD A LONG-TERM HISTORICAL MEDICAL RELATIONSHIP AND WHICH EMPLOYED VIRTUALLY ALL OF THE INTERNS AND RESIDENTS PROVIDING SERVICES AT THE HOSPITAL. THE DEFICIT REDUCTION ACT OF 1984 (P. L. 98-369), ENACTED ON JULY 18, INCLUDED AN AMENDMENT WHICH, EFFECTIVE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 1984, PERMITS A HOSPITAL TO COUNT ALL OF THE INTERNS AND RESIDENTS PROVIDING SERVICES IN THE HOSPITAL. SINCE THE NUMBER OF INTERNS AND RESIDENTS WORKING IN HOSPITALS DIRECTLY AFFECTS THE AMOUNT OF PAYMENT, WE ARE CURRENTLY DEVELOPING PROCEDURES TO ASSURE THAT UNDER THE REVISED RULES, A SINGLE RESIDENT OR INTERN IS NOT COUNTED AS MORE THAN ONE FULL-TIME EQUIVALENT EMPLOYEE REGARDLESS OF

THE NUMBER OF HOSPITALS IN WHICH HE OR SHE PERFORMS SERVICES.

EFFECT OF POLICIES FOR REIMBURSING MEDICAL EDUCATION COSTS

THE PASS-THROUGH OF DIRECT MEDICAL EDUCATION COSTS AND THE ADDITIONAL PAYMENT FOR INDIRECT MEDICAL EDUCATION COSTS HAVE A SIGNIFICANT FISCAL IMPACT ON THOSE HOSPITALS HAVING APPROVED INTERN AND RESIDENCY PROGRAMS. THE INDIRECT MEDICAL EDUCATION PAYMENT, IN A BUDGET NEUTRAL CONTEXT, HAS AN EFFECT ON INSTITUTIONS WITHOUT TEACHING PROGRAMS, TOO. WE HAVE ESTIMATED THAT IF ALL HOSPITALS UNDER THE PROSPECTIVE PAYMENT SYSTEM HAD BEEN REIMBURSED SOLELY ON THE BASIS OF THE FEDERAL REGIONAL RATE IN FISCAL YEAR 1984, THE APPROXIMATELY 118 "HEAVY" TEACHING HOSPITALS (THOSE HAVING A RATIO OF ONE OR MORE INTERN OR RESIDENT FOR EVERY FOUR BEDS) WOULD HAVE RECEIVED AN AVERAGE OF $756 PER CASE FOR DIRECT MEDICAL EDUCATION AND $2,158 PER CASE FOR INDIRECT MEDICAL EDUCATION, WHILE THEIR DRG PAYMENT PER CASE WOULD HAVE BEEN $4,079. THUS, THEY WOULD BE RECEIVING A 53 PERCENT ADD-ON TO THEIR DRG PAYMENT FOR INDIRECT MEDICAL EDUCATION AND AN ADDITIONAL $756 FOR DIRECT MEDICAL EDUCATION. THE EFFECT IS SUCH THAT FOR "HEAVY" TEACHING HOSPITALS, THE AVERAGE DIRECT AND INDIRECT TEACHING PAYMENTS PER CASE IS ABOUT THE SAME AS THE ACTUAL DRG PAYMENT PER CASE FOR NONTEACHING HOSPITALS.

FOR THE REMAINING HOSPITALS WITH TEACHING ACTIVITIES, APPROXIMATELY 654 FACILITIES, IN ADDITION TO THE AVERAGE DRG PAYMENT PER CASE OF $3,659, WOULD RECEIVE AN ESTIMATED ADDITIONAL 10 PERCENT FOR INDIRECT AND ANOTHER 6 PERCENT FOR DIRECT MEDICAL EDUCATION. OUR SIMULATION INDICATES THAT APPROXIMATELY $204 PER CASE WOULD BE WITHHELD FROM ALL HOSPITALS SO THAT ALL THE TEACHING HOSPITALS COULD RECEIVE AN AVERAGE OF APPROXIMATELY $613 PER CASE FOR INDIRECT MEDICAL EDUCATION.

WE WILL BE CLOSELY MONITORING EXPENDITURES FOR MEDICAL EDUCATION AS THE SYSTEM PHASES-IN TO A FULLY PROSPECTIVE FEDERAL RATE, AND WE HOPE TO IDENTIFY IMPROVEMENTS WHICH COULD BE MADE IN THE METHOD OF REIMBURSEMENT FOR MEDICAL EDUCATION COSTS. AS PART OF THIS EFFORT, THE DEPARTMENT IS CURRENTLY SPONSORING A MAJOR STUDY OF THE FINANCING AND COST OF GRADUATE MEDICAL EDUCATION. FINDINGS ARE EXPECTED IN MID-1985.

IN ADDITION, IT MAY BE THAT THE HIGH COSTS ASSOCIATED WITH TEACHING HOSPITALS ARE RELATED TO UNMEASURED DIFFERENCES IN CASE MIX ACROSS HOSPITALS. HCFA IS CURRENTLY INVESTIGATING SEVERAL APPROACHES FOR IMPROVING CASE MIX MEASUREMENT. IF THIS EFFORT IMPROVES OUR ABILITY TO MEASURE CASE MIX AND RESOURCE REQUIREMENTS, THE NECESSITY FOR PROVIDING AN ALLOWANCE FOR INDIRECT MEDICAL EDUCATION COSTS MAY BE DIMINISHED.

MR. CHAIRMAN, THIS CONCLUDES MY PREPARED STATEMENT. I WILL BE GLAD TO ANSWER ANY QUESTIONS YOU MAY HAVE.

STATEMENT OF DR. ROBERT GRAHAM, ADMINISTRATOR, HEALTH RESOURCES AND SERVICES ADMINISTRATION, PUBLIC HEALTH SERVICE, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Senator DURENBERGER. Dr. Graham.

Dr. GRAHAM. Mr. Chairman, as we discussed briefly last Friday, the Public Health Service interest in the area of graduate medical education financing derives from our Federal responsibility for issues such as distribution, access to services and making sure that the system has an adequate number of individuals properly trained to deliver the necessary services.

Historically, the PHS has had a major role in developing the capacity of that system. The investments that we have made from the late 1960's onward lead to a large expansion in the size of medical school and nursing school classes and the expansion of all other types of health professions training.

To some extent, this has created the problem that we are dealing with: how to educate health professionals in a cost-effective and equitable fashion. The training programs supported by the Public Health Service are relatively modest. We provide direct grant support for training programs in family medicine, primary care internal medicine, and primary care pediatrics. These grants offset some of the costs of sponsoring and carrying out those programs. They are specifically in the areas of primary care because that is the area where we are trying to work in partnership with the academic and practicing communities to correct an imbalance in terms of the percentage of physicians who are in specialty versus primary care medicine.

However, these and certain other highly focused activities are about the limit of our direct role in health professions education now. We continue, though, to be concerned with the outcome of the debate, the scope of which you sketched in your opening statement.

The graduate education system is a complicated, pluralistic system. Thousands of decisions are made by persons across the country every year in determining how many residency training positions will be offered in which specialties and in which locations. To try to find ways to bring those decisions more in line with national policy, and to make them more cost effective raises some fundamental issues as to how those decisions are made. Decision making is pluralistic, not centralized.

We also must recognize that there are costs for health professions education. And the debate should focus on the public role—Federal, State and other—in supporting those costs for education. We cannot allow our vision to be obscured by thinking that there is some way to save money, that somehow these costs are going to be picked out magically. There are real costs. Someone must pay them.

As I have noted, the Public Health Service has a relatively modest grant role in training health professionals. Our real responsibility is trying to make sure that there is balance in the system, that the resources are somewhat matched with the needs, that care is delivered to people who need it, and that the issues are approached in a methodical, thoughtful way.

I'm encouraged by some of the issues you raised in your opening statement. It appears to me that that is the scope that this committee is ready to take on.

But, first, I think there needs to be some agreement on principles. If we just concentrate on cost, the principles slip away from us. And the first principle is who is responsible for cost. Is it a public responsibility? Should it come from the "sick fund"? Should it come from Medicare-Medicaid revenues? Should it come from insurance funds? Or should there be some new way of paying for it?

Regardless of what we think the cost should be, the first principle's who pays. And, I think, we need to come at it from the view point of principles first and cost second, rather than cost first and then hoping we can back into a set of principles that we can live with. This is a tremendously complex, decentralized, pluralistic system. It has served us exceptionally well over the past two decades. That's not to say that it is without problems in terms of cost or internal maldistribution. But it is a system that is functioning generally very well.

As we change it, because of our concerns about cost and equity, I hope that we can do so after discussing a set of principles, and not be driven solely by concern for cost.

Senator DURENBERGER. Thank you, Dr. Graham.

[The prepared written statement of Dr. Graham follows:]

STATEMENT BY ROBERT GRAHAM, M.D., ADMINISTRATOR, HEALTH RESOURCES AND SERVICES ADMINISTRATION

STATEMENT BY

ROBERT GRAHAM, M.D.,

ADMINISTRATOR, HEALTH RESOURCES

AND SERVICES ADMINISTRATION

Mr. Chairman and Members of the Subcommittee:

I am Dr. Robert Graham, Administrator of the Health Resources and Services Administration. I am please to be here to discuss Medicare funding of medical and other health professions education. I am especially pleased by the Subcommittee's interest in first examining the present system and how it is working before considering any changes.

Most of the discussion of the impact of changes in reimbursement for educational programs has centered around the training of the nearly 70,000 medical interns and residents in approved programs. Other programs directly sponsored by hospitals include nursing programs and allied health professions programs.

In addition to the direct operation of educational programs, hospitals also play a role as the major clinical facilities for collegiate sponsored programs. Approximately 60% of all hospitals serve in this capacity.

The present Medicare educational reimbursement system is primarily focused on the intern and residency programs with only a small portion of the expenditures directly supporting the other health professions. The Association of American Medical Colleges estimated that about 80 percent of the hospital costs for residents' salary, fringe benefits, etc. in 1982 came from patient revenue and general operating appropriations. The financing of other programs is some combination of tuition, grants, and hospital support from other revenues. Often the use of the hospital as a clinical facility by schools of nursing and allied health programs is through affiliation agreements in which no money exchanges hands.

Comments with respect to the present method of Medicare financing of educational programs include the following:

- The present indirect teaching adjustment was intended to account for various factors such as severity of illness in teaching hospitals. It therefore should not be confused with actual clinical education costs.

- If Medicare were no longer to support graduate health professions education, then alternative sources of funds may have to be found. The impact of such reductions on the health work force itself cannot be estimated at this time.

- Virtually all health professions education involves informal arrangements between the sponsoring academic institution and the facilities (mostly hospitals) that provide clinical instruction. Many such arrangements (which offer hospitals a source of recruitment and other benefits such as academic appointments for hospital staff) have been carried out without cost to the academic institution. The impact of these changes on reimbursement policy or general cost-cutting measures resulting from hospitals eliminating such agreements must be evaluated in developing an alternative to the current system.

In closing, I would like to emphasize our concern that the present system and proposed alternatives be studied in detail before decisions are made. Our agency, in coordination with the Health Care Financing Administration,

is beginning to address this issue in some depth. For example, two of our councils, the National Advisory Council on Health Professions Education and the National Advisory Council on Nurse Training, are assisting us in developing a strategy to assess the potential impact of changes in hospital financing, including Medicare's Prospective Payment System, on health professions education.

I would like to thank you for this opportunity to address this Subcommittee and would be happy to answer any questions.

FIGURE 3 (Revised)

SOURCES OF STUDENT FINANCIAL ASSISTANCE, 1974-75 THROUGH 1982-83
(DOLLARS IN THOUSANDS)

	1974-1975	1975-1976	1976-1977	1977-1978	1978-1979	1979-1980	1980-1981	1981-1982	1982-1983
SERVICE CONTINGENT SCHOLARSHIPS	29,379	46,387	48,619	56,154	71,868	88,782	98,248	94,491	82,853
Armed Forces	14,744	21,013	21,190	24,757	29,600	32,666	38,029	44,810	48,840
National Health Service Corps	8,017	16,625	16,592	25,194	37,932	49,815	50,111	38,721	23,474
Other	6,618	7,759	8,837	4,203	4,428	6,409	11,108	10,960	9,719
OTHER SCHOLARSHIPS	22,686	22,187	23,484	25,290	32,662	32,880	37,128	48,781	50,976
School Funds	14,010	15,068	15,013	18,334	20,044	20,672	23,078	27,180	30,760
Medical Scientist Training Program (MSTP)	-	-	-	-	-	-	-	7,727	7,910
Exceptional Financial Need Scholarship (EFN)	-	-	-	-	2,545	3,551	5,135	4,900	2,449
Other	8,675	7,039	8,011	6,965	10,073	8,644	8,915	9,974	9,867
LOANS	71,000	81,300	95,214	126,162	155,568	213,175	284,686	319,675	306,686
Guaranteed Student Loans	38,700	40,599	50,143	78,957	105,748	150,317	189,344	220,699	183,246
Health Professions Student Loans	21,316	20,077	18,678	18,965	19,754	17,584	22,684	24,348	22,950
Health Education Assistance Loans	-	-	-	-	840	4,799	15,302	33,166	50,436
National Direct Student Loans	-	-	2,988	9,301	12,804	17,357	16,841	12,737	14,910
PLUS Loans	-	-	-	-	-	-	-	2,004	11,256
Private Funds	13,101	14,233	15,942	11,212	13,123	15,108	11,434	9,016	5,986
School Funds	5,975	6,373	7,463	7,727	7,300	8,520	9,290	9,625	16,822
COLLEGE WORK STUDY	-	-	-	775	775	1,450	1,441	1,663	1,681

Senator DURENBERGER. I have only one small disagreement, I guess. Rather than having the first principle be who pays, I think the first principle is what is it you want to sell me. And I don't think you would disagree with that. That probably is the thrust of these two hearings. What are we buying now? And how is that perceived by the various consumers?

I take it you wouldn't disagree with that.

Dr. GRAHAM. No. I actually wrote down "who, what, why, and how much." But those are the principles that I think have to be agreed upon.

Senator DURENBERGER. Have you come to judgment on the role the public has been playing in the last 15 years or something like that? As I perceive the public role, it really hasn't been a public role. It has been a series of studies based on articles that have been written and concern that has been demonstrated about shortages or inaccessibility or distribution or whatever. And then a congressional response out of which a very small amount of the public is involved. And then a couple of years after the problem is at its most severe, there is some congressional activity in one line of title 7 of the Public Health Services Act or some of these other titles and/or some kind of capitation for graduate medical education. And then along about the time the problem is gone and we start seeing surpluses, we can't give up any of these things. And so 4, or 5 or 6 years later, the so-called public has to say, "Hey, what are you spending on that for?"

That strikes me as the way the public has been interfacing with the problem of needed adequate numbers of health professionals. What conclusion have you come to about the way we have been proceeding to involve the public in the last 15 years?

Dr. GRAHAM. Prior to 1960, there was little direct involvement on the part of the Public Health Service in health professions education. Then there developed a general perception that we had a substantial shortage of most types of health professionals. As a result, we embarked upon capacity building, providing money for new buildings, and more faculty. The schools cooperated. The States responded with State funds. Capacity grew very rapidly.

Senator DURENBERGER. And it covers the wide spectrum in this period of time of higher education.

Dr. GRAHAM. That's right.

Senator DURENBERGER. I mean we were financing student housing and a wide variety of things on college campuses all over the country.

Dr. GRAHAM. There was great concern as to whether the educational resources of the United States were adequate to meet the demands of the public and of the students. That was also the time we were dealing with the baby boom. A lot of people didn't know whether there were going to be places for those kids, for my generation. That was only 10 to 15 years ago.

Starting with the early to mid-1970's, we saw a change in the public role. The Public Health Service moved away from general open-ended support in medicine and the other health professions. Most capitation grants were phased out. PHS moved toward programs targeted at primary care, at redistribution, at changing the

mix of health professionals, disadvantaged assistance programs were strengthened.

That's where we are today. There is less money now than there was 4 or 5 years ago. As long as there is a general perception that there is an adequate and increasing supply of health care professionals, you will see Public Health Service support for health professions education remain at a very modest level.

Senator DURENBERGER. And that whole issue of distribution and access I hope we will get into again with you or someone else in our next hearing because you are right. There is a perception out there that we have solved the problem and there is a surplus. But I think there are a lot of areas of this country which you could go to today where they would disagree with regard to their particular communities or areas.

Dr. GRAHAM. The single most profound change that will influence the practice of medicine over the next 10 years is the very large increase in the number of practicing physicians. Intellectually we have a difficult time dealing with what it will mean that by the mid to late 1990's there will be 40 percent more practicing physicians in the United States than there are today. But those numbers are there. The physicians are in the pipeline. They are going to change the face of the policy issues that we are dealing with.

Senator DURENBERGER. Let me ask you a question relating to a specific population. That's the one largely covered by Medicare, the elderly. All the demographics point to a substantially increasing number of elderly. And, obviously, we expect to see a rather substantial demand for health care which is geared to treating chronic and other conditions associated with that age group.

I have been given the impression by a variety of people, including the fellow that is leaving as head of the medical school in Minnesota, and going off to, in effect, study one specialty, I think, that particularly affects the aging. There is an awful lot that we yet need to know about the problems, health problems, that face the aging in this country. In the Public Health Service, are you planning any particular programs or recommendations that might be targeted toward solving that problem? Or would it be appropriate for us to conclude that academic and medical center environments are probably the best places to solve that problem because of the particular mix of talents that you would look for to concentrate on these problems of aging?

Dr. GRAHAM. We are doing two things that respond to that problem. One is narrow and targeted and one is more general. In a targeted fashion, our agency is working with the National Institute of Aging on several projects that relate to the development of geriatric curriculums for the various health disciplines. We feel that there is a need to further develop a cadre of health professionals—physicians, dentists, nurses, pharmacists, who have special competence in the area of geriatrics.

However, in the broader sense, we must be able to train over the next 5 to 10 years a stable population of primary care providers who can care for individuals in the mainstream. I do not think that the answer to providing services to our aging population is to provide those services only through geriatricians. Those services should be provided through broadly trained, generalist physicians,

who have the consulting resources of the geriatricians to rely on in particularly complicated cases. We should not sequester our elderly population for treatment by physicians in a totally new medical specialty.

Senator DURENBERGER. I wonder if that's a bridge—and this is only a recollection to Dr. Desmarais—I thought I saw in your statement, or maybe it was somebody else's, some indication that the way the present reimbursement system for indirect medical education works is that such things as family practice specialties were probably not compensated as well as some other specialties, and that some of the work was done outside of the hospital, and so forth. That was not your statement?

Dr. DESMARAIS. Not my statement. But certainly it's true that the indirect adjustments are only for inpatient care, so the extent of outpatient care wouldn't be reflected in the indirect medical education adjustments.

Senator DURENBERGER. Why don't you pick up on that subject a little bit and tell me if because the way we are reimbursing today, are we, in effect, skewing in some way the reimbursement system in favor of certain medical specialties and away from others?

Dr. DESMARAIS. Well, we don't believe we are. Certainly the way we reimburse today is largely a historic phenomenon and a judgment being made that until something else was done, that Medicare ought to pay its share of the medical education costs. And each intern and every resident in the facility has the same count, if you will—they have the same value for purposes of indirect medical education adjustment. And certainly most programs have an inpatient component, a very large inpatient component.

Senator DURENBERGER. I think your statement says that there aren't any incentives, or very few, if any, incentives in the current reimbursement system to restrain medical education costs under the Medicare program. Is that correct?

Dr. DESMARAIS. That's true. On the direct side is the cost passthrough. So until something else occurs, there is no incentive there. And on the indirect side, there is a formula. And unless the formula is changed from 11.59 percent—or some similar number based on up to date data—that simply factored in, every case results in an additional 11.59-percent reimbursement in a teaching hospital for every 0.1 ratio of interns and residents to beds.

Senator DURENBERGER. Now what's the evidence out there that somebody is taking advantage of that lack of incentive? Is there any yet?

Dr. DESMARAIS. We really don't have any evidence yet of the appropriateness or inappropriateness of that number. Clearly, that was a judgment Congress reached feeling that, without doubling, it was inadequate to support the teaching programs, and so it was doubled.

Senator DURENBERGER. Can you give me a little scoping of where the graduate medical education is being provided in this country? Who are the beneficiaries of graduate medical education? In terms of whether the numbers are concentrated, whether there are any people in rural areas benefiting in any way from graduate medical education programs? Are there differences among various types of hospitals? In other words, a teaching hospital that is part of an

academic medical center as opposed to some others? What does the landscape look like across the country right now?

Dr. DESMARAIS. Well, certainly it should come as no surprise that the bulk of the teaching hospitals are located in urban areas. In fact, I think of hospitals under prospective payment, of the total teaching hospitals, there are only 56 of them located in rural areas. And the total is 772. So the bulk of them do fall in urban areas. I'm not sure if we have other data that would indicate exactly who receives the care.

Senator DURENBERGER. What's the consequence of that, in your opinion?

Dr. DESMARAIS. Well, the consequence of that, I think, is that if you are in a rural area, it's very likely that you will have to travel to a nearby urban area to receive specialized care in a teaching setting. For those who receive care in teaching centers, there are advantages and disadvantages to that care, obviously. Some feel that's the best care. Others feel, well, they don't like to be poked by medical students and so on. So some people seek out tertiary care in a teaching setting and others don't. I guess it depends on the problem that confronts that patient and the physicians who do the referring.

Senator DURENBERGER. What kind of market is there out there for residents? Is there a lot of competition among hospitals for residents? On what basis are decisions made about where all of these residents go?

Dr. DESMARAIS. There is certainly a lot of competition. We are reaching the point where there is an intern or resident waiting for nearly every slot in a hospital. And perhaps Dr. Graham would want to elaborate on that. So there is a fair amount of competition.

Basically, the system is a matching system so that medical students in their fourth year are matched to "the facility of their choice." It may be their fourth choice or their fifth choice, but it's the facility of their choice through a computerized match system.

Senator DURENBERGER. Do you want to expand on that, Bob?

Dr. GRAHAM. Yes. It's kind of like committee assignments. [Laughter.]

The competition among residents is for a hospital or a training program. Most of the hospitals and the training programs review the credentials of the more qualified applicants. Through a computerized matching system, they select those they prefer. They try to match highest choices of residents with highest choices of programs.

A related phenomenon going on now is of major concern to us, to academic medicine. There is a possibility that because of uncertainties, new reimbursement systems, and the cost of graduate medical education and hospitals, the number of total residency positions may decrease not only modestly but precipitously. We could come to a situation in the relatively near future where there would not even be enough residency positions in the United States for all of our medical graduates. We are not in that position now, but we are much closer to it than we were 5 or 6 years ago.

As economic incentives change in the teaching hospitals, there is less and less of a passthrough psychology. Formerly it didn't make any difference if there were eight surgical sponsors; those costs

were just passed through. If I thought I needed a faculty of 10, I could have 10. Now the incentives may well pit the hospital administrator against the program chairman. The administrator may not be sure if the hospital can afford eight. How about six?

If that happens program by program in a decentralized fashion with not everyone knowing what everybody else is doing, we could lose a fairly large number of positions in a year or two.

Senator DURENBERGER. You are probably right that we could get on this one for some period of time, and maybe that is an area that I would ask you to respond in writing.

I am curious to know, obviously, if the competition is really among residents for slots to get to be one, two, three, four. If I could crawl inside that computer, who is No. 1, who is No. 2. I assume I could tell if I just looked through that computer. I could tell which of the teaching hospitals in the country is the one that the most people would like to go to. And then I would ask questions about why.

Dr. GRAHAM. It may vary program by program.

Senator DURENBERGER. That I understand.

Dr. GRAHAM. The most attractive internal medicine programs may be in the hospital that does not have an attractive surgery program.

Senator DURENBERGER. I understand that. But I could theoretically get inside this computer and look over a couple or 3 or 4 years and I would find out by reputation who is No. 1.

Dr. DESMARAIS. It's a very individualized situation. The intern, the potential intern, may be looking for a part of the country to settle in or looking for a particular professor to work under to do specific research. It just varies tremendously, and it certainly varies by program because one part of the country may have the best pediatric program and another part may have the best internal medicine program. And those numbers, of course—there is a lot of competition between our educational centers as well.

Senator DURENBERGER. I take it also that it might require a little elaboration for you to define the word "afford" in the sense of the negotiation between the hospital administrator and the people that want the residency position. And I may ask that question of some of the people from the teaching hospitals.

I have a dozen other questions of each of you that I will submit to you in writing. My appreciation to both of you for being here, and we will see you again at the next hearing.

Dr. DESMARAIS. Thank you.

Dr. GRAHAM. Thank you.

Senator DURENBERGER. Our next panel consists of Dr. John A.D. Cooper, president of the Association of American Medical Colleges; C. Thomas Smith, president of Yale-New Haven Hospital, New Haven, CT, on behalf of the Association of American Medical Colleges; Dr. Edward Stemmler, dean of the School of Medicine, University of Pennsylvania, on behalf of the Association of American Medical Colleges.

Gentlemen, I believe you were all here for the opening statement. You have some feel for the scope of the hearing today judging from your prepared statements. You have gone beyond the

scope in being helpful to us. And, personally, I appreciate that a great deal.

So your entire statements, together with any responses to questions that we may submit to you in writing, will be made part of the record. And you may proceed to summarize those statements in whatever order you would like to go.

Dr. Stemmler?

Dr. STEMMLER. Yes, thank you, Mr. Chairman.

STATEMENT OF DR. EDWARD J. STEMMLER, DEAN OF THE SCHOOL OF MEDICINE, UNIVERSITY OF PENNSYLVANIA, ON BEHALF OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES, WASHINGTON, DC

Dr. STEMMLER. First, I must comment that Dr. Cooper unfortunately could not be at this hearing. But nonetheless I want you to know the association is well represented.

Senator DURENBERGER. I came to that same conclusion. [Laughter.]

Dr. STEMMLER. Mr. Chairman, and members of the committee——

Senator DURENBERGER. We had another of your colleagues in here on Friday that couldn't be here today. It was also more than adequately represented.

Dr. STEMMLER. Well, I'm Dr. Edward J. Stemmler. I'm dean of the school of medicine of the University of Pennsylvania. And let me first say that our association, on whose behalf I appear, welcomes the opportunity to address this committee.

While the major focus of today's hearing is on the financing of graduate medical education, it is my understanding that the committee has expressed an interest in securing a broader picture of how medical education is financed; particularly, at the undergraduate level. Therefore, my presentation will address this broader issue. First, from the point of view of the student. And then from the point of view of the medical school.

Now the task confronting the medical student is somehow to pay for tuition, fees, and living expenses for a 4-year course in undergraduate medical education. I will refer to a series of figures which are attached to my testimony, and take this opportunity to point out that figure 3 in that set of figures has been revised because of a certain inaccuracy in the figure that we provided in our lengthy statement.

But in figure 1, we show that on the average tuitions and fees have risen substantially over the last quarter of a century, both in current and constant terms. However, many State governments have held these charges down, and thereby have essentially provided a partial scholarship to students attending the publicly supported schools.

Students fund their tuition and living costs through out of pocket expenditures, through scholarships, or through borrowing. A small, diminishing fraction of seniors, 26 percent in 1979 and 12 percent in 1984, reported no debt at the time of graduation. Included in this group were those whose total support was derived from personal or family resources or from scholarship assistance.

The available sources of scholarship funds are shown on that revised figure 3. Most are service contingent. The noncontingent Federal scholarship money for students and exceptional financial need is small and is shrinking.

At the time of graduation, a large and growing fraction of seniors—74 percent in 1978 and 88 percent in 1984—report that they have incurred debts to finance their education. As shown in figure 3, the sources from which the educational funds are borrowed are displayed. A low-cost Guaranteed Student Loan, the GSL Program, is by far the most heavily utilized. But as statutory borrowing limits on this instrument are exhausted, students have increasingly turned to the high-cost Health Education Assistance Loan Program [HEAL]. The latter also federally guaranteed is expanding rapidly. Revolving funds of modest size, composed of institutional and matching Federal contributions under a national direct student loan and health profession student loan programs have provided many students small low-cost loans.

To service contingent scholarship programs, the National Health Service Corps, and the Armed Forces Health Profession Scholarship Programs, designed to meet the personnel needs of the Federal Government have been available to students willing to make the prescribed commitments, although the NHSC Program has been curtailed in recent years.

Figure 4 shows the total dollars loaned, the numbers of loans originated, and the average loan size for each of these loan programs for the last 2 academic years.

Figure 5 displays other important data on senior students who accrued debt in order to finance their education. The number has increased substantially. In the last 5 years, the mean debt has almost doubled. The fraction with debt in excess of $30,000 has almost tripled, and the fraction whose debt exceeds $50,000 has almost quintupled.

In the face of these data, one cannot suppress a deep concern that the current high costs of medical education threaten to make it difficult for anyone but those from wealthy families to undertake a course in medical studies.

Let's turn to the medical schools. In any discussion of medical school financing, it is essential to recognize that the function of these institutions and their faculties is no longer simply to produce physicians. Other faculty activities—education programs for an extensive array of medical specialists and subspecialists and of other health professionals, a steady flow of basic and clinical research results, frequent contributions to technological developments and improvement, a large volume of medical service in both inpatient and outpatient settings, and a host of others, including community outreach activities. Virtually all individual faculty members are engaged in multiple functions.

Medical schools derive income from both government and nongovernmental sources for the operation of programs in education, research, and patient care. About 38 percent of the total revenue budget is earmarked for sponsored or restricted programs with the remainder available for general operations. And summary data on these revenue streams in both current and constant dollars is shown in figures 6A through 6D.

Federal research awards are a major source of revenue for medical schools. In 1982-83, 16.7 percent of public and 24.5 percent of private school revenues—and I must emphasize equal and offsetting expenditures were derived from Federal research awards. Activities supported through these funds have, over the last several decades, contributed enormously to the exciting intellectual ambiance of U.S. medical schools and the frontiers of knowledge have been steadily and relentlessly pushed back.

Other Federal income includes the words under Federal training, education and service programs. And, principally, reimbursements for expenditures incurred in indirect costs on federally sponsored programs.

Public schools derive a substantial 36 percent of their revenues from the regular appropriations of State educational institutions. They are to variable degrees subject to expenditure limitations.

Tuitions and fees account for about 6 percent of medical school revenues—3 percent for the public and 9 percent for the private schools. This income estimated to reimburse only about 10 to 20 percent of the cost to the institutions for educating students still constitutes a severe burden to the students.

The medical service revenues come principally from professional fees generated by faculty members from their patient care activities. In addition, affiliated hospitals reimburse medical schools for that part of a faculty member's time and effort devoted to activities that are essentially hospital specific.

In 1982-83, this source accounted for 26.5 percent of the gross revenues of the public, and 36 percent of the private schools.

Over an extended period, the relative importance of the several revenue streams has changed, as shown in figure 7. Federal sources, principally research, reached a peak in the mid-1960's, but subsequently fell to about 25 percent. Federal manpower expenditures and medical school revenues therefrom, including capitation awards after a mediocre rise in the mid-1960's, declined precipitously as public and congressional concerns over a physician burden became less urgent.

Tuition income, while increasing both in current and constant dollars, remained a relatively small and steady source of income. State and local government contributions have increased both absolutely and relatively. This is attributable to the fact that the lion's share of the recent expansion of medical school capacity was under the aegis of the States.

Revenue from medical service is the most rapidly growing source of income for all schools.

I hope this presentation has been informative. And I must say it's the fastest briefing on medical school financing that I have ever given. And I will be happy to answer any questions, Mr. Chairman, that you might want to ask.

Senator DURENBERGER. Thank you very much.

[The prepared written statement of Dr. Stemmler follows:]

TESTIMONY

OF THE

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

FINANCING OF UNDERGRADUATE AND GRADUATE MEDICAL EDUCATION

Mr. Chairman and Members of the Committee. I am Dr. Edward J. Stemmler, Dean of the School of Medicine of the University of Pennsylvania. Let me first say that the Association of American Medical Colleges, on whose behalf I appear, welcomes the opportunity to address this Committee.

While the major focus of today's hearing is on the financing of graduate medical education, it is my understanding that the Committee has expressed an interest in securing a broader picture of how medical education is financed, particularly at the undergraduate level. Therefore, my presentation will address this broader issue, first from the point of view of the student, and then from that of the medical school.

How Students Finance Their Education

The task confronting the medical student is, somehow, to pay for tuition, fees and living expenses during a four year course of undergraduate medical education.

As shown in Figure 1, on the average tuition and fees have risen substantially over the last quarter of a century, in both current and constant terms. However, many state governments have held these charges down and, thereby, have essentially provided a partial scholarship to students attending public schools.

Students fund their tuition and living costs through "out-of-pocket" expenditures, scholarships or borrowing.

A small and diminishing fraction of seniors---26% in 1979 and 12% in 1984---reported no debt at the time of graduation. Included in this group are those whose total support was were derived from personal or family

resources, or from scholarship assistance. The available sources of scholarship funds are shown in Figure 3. Most are service contingent; the non-contingent Federal scholarship money, for students in exceptional financial need, is small and shrinking.

At the time of graduation a large and growing fraction of seniors---74% in 1978 and 88% in 1984---report that they have incurred debt to finance their education. Also shown in Figure 3 are the sources from which educational funds are borrowed.

The low cost Guaranteed Student Loan (GSL) program is by far the most heavily utilized. But as statutory borrowing limits on this instrument are exhausted, students have increasingly turned to the high cost Health Education Assistance Loan (HEAL) program. The latter, also federally guaranteed, is expanding rapidly. Revolving funds of modest size, composed of institutional and matching Federal contributions under the National Direct Student Loan (NDSL) and Health Professions Student Loan (HPSL) programs, have provided many students small low cost loans.

Two service contingent scholarship programs---the National Heath Service Corps (NHSC) and the Armed Forces Health Professions (AFHP) scholarship programs---designed to meet the personnel needs of the Federal government, have been available to students willing to make the prescribed commitments, although the NHSC program has been curtailed in recent years.

Figure 4 shows the total dollars loaned, the number of loans originated and the average loan size for each of these loan programs for the last two academic years.

Figure 5 displays other important data on senior students who accrue debt in order to finance their education. The number has increased substantially in the last five years, the mean debt has almost doubled; the fraction with debt in excess of $30,000 has almost tripled; and the fraction whose debt exceeds $50,000 has more than quintupled.

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How Medical Schools Are Financed

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Medical schools derive income from both government and non-government sources for the operation of programs in education, research and patient care. About 38% of this is earmarked for sponsored or restricted programs, with the remainder available for general operations. Summary data on these revenue streams in both current and constant dollars, is shown in Figures 6A through 6D.

Federal research awards are a major source of revenue for medical schools. In 1982-1983, 16.7% of public and 24.5% of private school revenues---and equal and off-setting expenditures---were derived from Federal research awards. Activities supported through these funds have, over the last several decades, contributed enormously to the exciting intellectual ambiance of U.S. medical schools, as the frontiers of knowledge have been steadily and relentlessly pushed back.

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Tuition and fees account for about 6% of medical school revenues, 3% for public, and 9% for private, schools. This income estimated to reimburse only 10-20% of the costs to the institutions for educating them, still constitutes a severe burden on the students.

The medical service revenues come principally from professional fees generated by faculty members from their patient care activities. In addition, affiliated hospitals reimburse medical schools for that part of a faculty member's time and effort devoted to activities that are essentially hospital specific. In 1982-1983, this source accounted for 26.5% of the gross revenues of the public, and 36% of the private, schools.

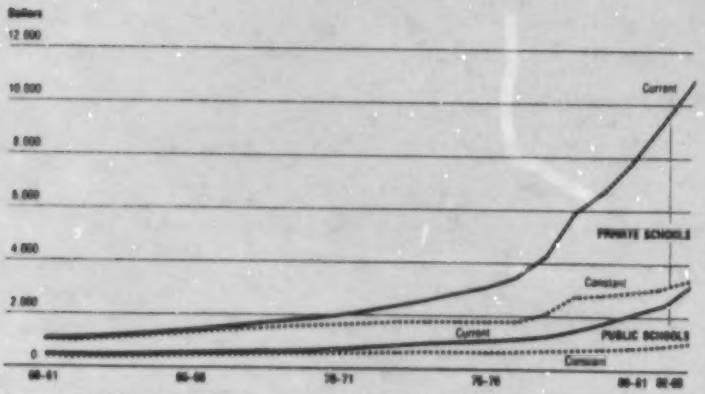
Over an extended epoch, the relative importance of the several revenue streams has changed, as shown in Figure 7. Federal sources, principally

research, reached a peak in the mid-60's but subsequently fell to about 25%. Federal manpower expenditures---and medical school revenues therefrom---including capitation awards, after a meteoric rise in the mid-60's, declined precipitously as public and Congressional concerns over a physician shortage became less urgent. Tuition income, while increasing in both current and constant dollars, remained a relatively small and steady source of income. State and local government contributions have increased both absolutely and relatively. This is attributable to the fact that the lion's share of the recent expansion of medical school capacity was under the aegis of the states. Revenue from medical service is the most rapidly growing source of income for the schools.

I hope this presentation has been informative on the financing of undergraduate medical education. I would be happy to answer any questions that it has evoked. Thank you.

FIGURE 1

U.S. MEDICAL SCHOOL MEDIAN TUITION AND FEES FOR FIRST-YEAR MEDICAL STUDENTS
1960-61 THROUGH 1982-83



Source: Medical School Admission Requirements

Constant dollars are 1982 dollars deflated by the Consumer Price Index

FIGURE 3 (Revised)

SOURCES OF STUDENT FINANCIAL ASSISTANCE, 1974-75 THROUGH 1982-83
(DOLLARS IN THOUSANDS)

	1974-1975	1975-1976	1976-1977	1977-1978	1978-1979	1979-1980	1980-1981	1981-1982	1982-1983
SERVICE CONTINGENT SCHOLARSHIPS	29,379	45,307	48,819	54,154	71,968	98,782	99,248	94,491	82,033
Armed Forces	14,744	21,013	21,190	24,757	29,600	32,550	38,029	44,810	48,840
National Health Service Corps	8,017	16,625	18,592	25,194	37,932	49,815	50,111	38,721	23,474
Other	6,618	7,769	8,837	4,203	4,436	8,409	11,108	10,960	9,719
OTHER SCHOLARSHIPS	22,686	22,187	21,424	25,299	32,562	32,689	37,138	48,781	50,976
School Funds	14,010	15,068	15,013	18,334	20,044	20,672	23,078	27,100	30,760
Medical Scientist Training Program (MSTP)	-	-	-	-	-	-	-	7,727	7,910
Exceptional Financial Need Scholarship (EFN)	-	-	-	-	2,545	3,561	5,135	4,900	2,449
Other	8,676	7,039	5,811	6,965	10,073	8,466	8,915	9,974	9,857
LOANS	71,892	83,268	95,214	126,162	169,559	213,176	261,695	319,675	386,686
Guaranteed Student Loans	30,700	40,599	50,143	78,957	105,748	150,317	189,344	228,699	183,246
Health Professions Student Loans	21,316	20,077	18,678	18,965	19,766	17,684	22,684	24,348	22,960
Health Education Assistance Loans	-	-	-	-	840	4,289	15,302	33,166	50,436
National Direct Student Loans			2,988	9,301	12,804	17,367	16,041	12,737	14,910
PLUS Loans	-	-	-	-	-	-	-	2,004	11,256
Private Funds	13,101	14,233	15,942	11,212	13,123	15,108	11,434	9,096	5,986
School Funds	6,975	8,373	7,463	7,727	7,288	8,520	9,290	9,625	16,822
COLLEGE WORK STUDY	-	-	-	775	775	1,400	1,441	1,487	1,401

FIGURE 4

Sources of Medical Student Financial Assistance

Sources	1981-82 Total Amount	1981-82 Number	1981-82 Average Amount	1982-83 Total Amount	1982-83 Number	1982-83 Average Amount
Scholarships						
Administered by schools						
Exceptional financial need	$ 4,099,584	418	$11,721	$ 2,448,861	172	$14,238
Medical Scientist Training Program	7,726,685	710	10,882	7,910,675	662	11,950
School funds	27,180,407	11,418	2,380	30,799,501	13,297	2,313
Other scholarships	9,062,014	6,248	1,450	9,174,466	6,283	1,460
Subtotal	48,068,690			50,293,503		
Not administered by schools						
Armed Forces health professions	44,809,664	3,263	13,733	48,840,030	3,171	15,402
National Health Service Corps	38,720,764	2,882	13,435	23,474,403	1,556	15,086
National medical fellowships	912,300	766	1,191	682,610	730	935
Other (with service commitment)	10,959,568	2,196	4,990	9,719,366	1,824	5,329
Subtotal	95,402,296			82,716,409		
Total Scholarships	144,270,986			133,009,912		
Loans						
Administered by schools						
Health professions loans	24,347,510	10,245	2,376	22,949,645	9,551	2,403
Guaranteed student loans	13,775,154	2,605	5,287	4,709,462	984	4,786
National direct student loans	12,737,413	7,216	1,765	14,909,736	8,057	1,851
Loans from school funds	9,624,746	6,283	1,531	16,822,076	7,495	2,244
Subtotal	60,484,823			59,390,919		
Not administered by schools						
Guaranteed student loans	214,923,028	43,809	4,905	178,536,448	37,624	4,745
Health education assistance loans	33,186,499	4,701	7,055	50,436,252	6,554	7,695
PLUS loans	2,004,325	752	2,665	11,256,451	3,930	2,864
Other loans	9,095,526	3,678	2,472	5,986,290	2,476	2,418
Subtotal	259,189,378			246,215,441		
Total loans	319,674,201			305,606,360		
College Work Study Program	1,482,911	1,274	1,163	1,401,763	1,092	1,284
Grand Total	465,428,098			440,018,035		

FIGURE 5

Debt Status of Senior Medical Students

1978-79 TO 1983-84

Year	Percent of Seniors with Debt	Mean Debt Of Seniors with Debt	Percent of Indebted Seniors with Debt Over $30,000	Percent of Indebted Seniors with Debt Over $50,000
1978-79	74%	15,663	N/A	N/A
1979-80	77%	17,212	11.4%	N/A
1980-81	77%	19,697	14.5%	1.5%
1981-82	83%	21,051	18.4%	2.9%
1982-83	86%	23,647	24.7%	4.7%
1983-84	88%	26,496	31.6%	8.1%

Source: AAMC Graduation Surveys

FIGURE 6A

Trends in U.S. Private Medical School Revenues

(millions of dollars)

Revenue Source	1967-68 Amount	1967-68 Percent	1972-73 Amount	1972-73 Percent	1977-78 Amount	1977-78 Percent	1982-83 Amount	1982-83 Percent
Federal Research	264	42.1	416	37.4	588	29.5	896	24.5
Other Federal	79	12.6	106	9.5	157	7.9	187	5.1
State and Local Gov't	32	5.1	90	8.1	108	5.4	159	4.3
Tuition and Fees	37	5.3	63	5.7	162	8.1	335	9.1
Medical Service	91	14.5	172	15.5	609	30.5	1,426	39.1
Other Income	127	20.3	264	23.8	371	18.6	655	17.9
Total	627	100.0	1,111	100.0	1,995	100.0	3,647	100.0

FIGURE 6B

Trends in U.S. Public Medical School Revenues (continued)

(millions of dollars)

Revenue Source	1967-68 Amount	1967-68 Percent	1972-73 Amount	1972-73 Percent	1977-78 Amount	1977-78 Percent	1982-83 Amount	1982-83 Percent
Federal Research	190	34.6	296	27.7	443	18.7	759	16.7
Other Federal	71	12.9	137	12.8	155	6.5	229	5.1
State and Local Gov't	151	27.5	332	31.0	914	38.5	1,629	35.9
Tuition and Fees	15	2.7	29	2.7	69	2.9	147	3.2
Medical Service	63	11.5	135	12.6	509	21.5	1,202	26.5
Other Income	59	10.7	140	13.1	282	11.9	564	12.4
Total	549	100.0	1,070	100.0	2,372	100.0	4,531	100.0

FIGURE 6C

Trends in U.S. Private Medical School Revenues

(constant 1967 dollars* in millions)

Revenue Source	1967-68 Amount	1967-68 Percent	1972-73 Amount	1972-73 Percent	1977-78 Amount	1977-78 Percent	1982-83 Amount	1982-83 Percent
Federal Research	264	42.1	329	37.4	332	29.5	342	24.5
Other Federal	79	12.6	84	9.5	88	7.9	71	5.1
State and Local Gov't	32	5.1	71	8.1	61	5.4	61	4.3
Tuition and Fees	33	5.3	50	5.7	92	8.1	128	9.1
Medical Service	91	14.5	136	15.5	344	30.5	544	39.1
Other Income	127	20.3	209	23.8	210	18.6	250	17.9
Total	627	100.0	878	100.0	1,128	100.0	1,392	100.0

FIGURE 6D

Trends in U.S. Public Medical School Revenues (continued)

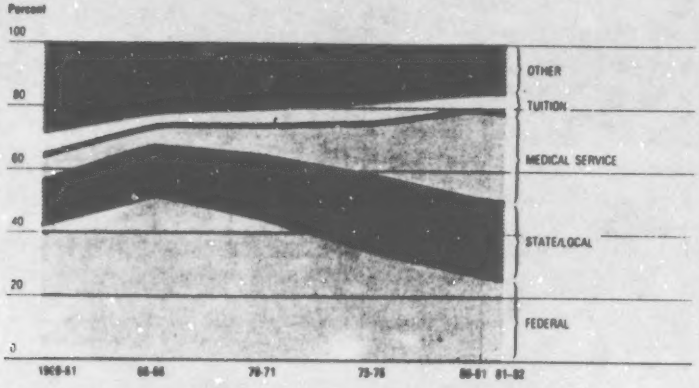
(constant 1967 dollars* in millions)

Revenue Source	1967-68 Amount	1967-68 Percent	1972-73 Amount	1972-73 Percent	1977-78 Amount	1977-78 Percent	1982-83 Amount	1982-83 Percent
Federal Research	190	34.6	234	27.7	250	18.7	290	16.7
Other Federal	71	12.9	108	12.8	88	6.5	87	5.1
State and Local Gov't	151	27.5	262	31.0	517	38.5	622	35.9
Tuition and Fees	15	2.7	23	2.7	39	2.9	56	3.2
Medical Service	63	11.5	107	12.6	288	21.5	459	26.5
Other Income	59	10.7	111	13.1	159	11.9	215	12.4
Total	549	100.0	846	100.0	1,341	100.0	1,729	100.0

* Constant dollar calculations are based on the GNP deflator.

FIGURE 7

DISTRIBUTION OF SOURCES OF REVENUE FOR MEDICAL SCHOOLS
1960-61 THROUGH 1981-82



Source: Association of American Medical Colleges

STATEMENT OF C. THOMAS SMITH, PRESIDENT, YALE-NEW HAVEN HOSPITAL, NEW HAVEN, CT, ON BEHALF OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES, WASHINGTON, DC

Senator DURENBERGER. Tom, are you going to pick up the rest of this statement?

Mr. SMITH. I would be happy to now or at your pleasure.

Senator DURENBERGER. Dr. Stemmler did a very good job of highlighting what looks like about the first half. And the next one is entitled "Graduate Medical Education." And it has a subtitle here called "Contemporary Graduate Medical Education." [Laughter.]

And you are in charge of one of those. Why don't you highlight that portion?

Mr. SMITH. I would be pleased to, Mr. Chairman.

I'm Tom Smith, a member of the administrative board of the association's Council of Teaching Hospitals. I appreciate the opportunity to share these concerns with you.

As a president of a major tertiary care teaching hospital, let me put my observation in context. Yale-New Haven Hospital in New Haven, CT, is an 863 bed and bassinet facility in which an average day witnesses 16 new births, 100 admissions, 200 visits in the emergency trauma facility, and another 700 in our outpatient center. Operating under the aegis of a regulatory agency, the Connecticut Commission on Hospitals and Health Care, the hospital has an expense budget of approximately $180 million and employs about 4,000 individuals.

This morning, the Yale-New Haven Hospital began its second year under Medicare's prospective payment system. In addition to the basic tertiary services which we offer, Yale-New Haven is the primary clinical training site for the Yale University School of Medicine, which has approximately 100 students per class. The hospital operates 18 residency programs with 250 residents and 50 clinical fellows in training.

Through my career, I have had the opportunity to work at five hospitals, all of which have been teaching institutions, but which have varied in a substantial degree in the level of their teaching engagement. I'm pleased to say one of those was the University of Minnesota Hospitals and Clinics.

Based on that experience, I would like to emphasize five points that are in the written testimony.

First, teaching hospitals fulfill a vital responsibility for our health care system. In order to maintain and replenish the Nation's supply of physicians, these hospitals advance knowledge based on temporary medicine, provide backup and specialized support for community hospitals, care for the most severely ill, provide access for the poor and for those with limited resources. These responsibilities are not organized in separate corporate divisions with carefully distinguished revenues and expenses. These services and responsibilities are provided simultaneously in a complex, highly interdependent enterprise. Therefore, I would caution against thinking that special needs of teaching hospitals can be addressed by a series of independent modifications to the prospective payment system. Even a subsidy for direct graduate medical education costs will be insufficient to insure the financial survival of major

teaching hospitals unless added support is also available for the severely ill patients, regionalized services, technology development, and charity care.

Second, in the last two decades, teaching hospitals have responded to the national mandate to increase the number of trained physicians. Completion of medical school doesn't mean a young man or woman is prepared to enter independent practice. An intense clinical training period must complement undergraduate medical education. As medical schools have grown and expanded in the last 20 years in response to Federal health manpower initiatives, teaching hospitals added the necessary residency training positions. Although now a cause of concern, cost reimbursement for direct residency training costs and recognition of the added hospital costs found to consistently accompany residency training, has allowed hospitals to provide an accredited residency for each graduating senior. Meeting this obligation of our medical school graduates is a major benefit in the present system and one that should not be overlooked. Any significant change must be in concert with the production of medical school graduates.

Third, teaching hospitals vary in their educational intensity and that variation is related both to the cost of providing graduate medical education and the special services of the hospital. A teaching hospital with 200 residents in 20 programs is very different from one with 25 residents in 3 programs. In a major teaching hospital, the whole institution must be devoted and maintained to support the dual missions of patient care and education. In smaller teaching hospitals, residency training is more clearly an incremental program and expense. As new alternatives for financing GME are considered, the needs of the relatively small number of comprehensive medical center hospitals must be given special consideration in addition to the needs of the affiliated community hospitals with more limited programs.

Fourth, Medicare provides teaching hospitals with cost reimbursement for the direct costs of training health personnel, including residents, plus a price adjustment in the DRG rates for indirect costs. The direct cost passthrough is easily understood, but the resident-to-bed adjustment is confusing because it's entitled the "indirect adjustment for costs accompanying medical education." Given this label, some incorrectly see this adjustment as solely for unmeasured medical education costs. However, the AAMC believes the adjustment is necessary primarily due to patient care costs which are inadequately measured by an average price DRG system. We agree with the Senate report which accompanied the prospective payment system which you quoted in your opening remarks.

While the statistical value of the adjustment may change as the DRG's are recalibrated and the wage index is improved and the system itself is refined, we urge the subcommittee to remember that the resident to bed adjustment is as important to maintaining the teaching hospital's capabilities as is the direct cost passthrough.

Finally, encouraging price competition in the delivery of health services makes sense only if all aspects of production are equal. The production of common products lends itself to a national average price, with providers challenged to operate efficiently. Howev-

er, the product produced by all hospitals are not the same, nor are the conditions under which they operate. Teaching hospitals are especially vulnerable under a competitive approach, absent special consideration for their multiple societal contributions. The strengths of our health care system will remain only if competition is equitable and if it provides the necessary financial recognition to hospitals with different missions and needs.

Teaching hospitals are a diverse group of highly complex institutions which we believe require special consideration. The current reexamination of national policies in light of limited public resources places teaching hospitals and their vital activities at significant risk. If national policies recognize the distinctive characteristics, their fundamental missions can be preserved. If these institutions are not given special consideration their capability to sustain their societal contributions will be jeopardized.

The rich history of teaching hospitals indicates that they are willing and capable of adapting to changes, circumstances and incentives. Their contributions require policies which make that possible.

Thank you, Senator.

Senator DURENBERGER. Thank you.

[The prepared written statement of Mr. C. Thomas Smith and Dr. Edward J. Stemmler follows:]

STATEMENT

OF THE

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Financing of Undergraduate and Graduate Medical Education

Presented to the Subcommittee of Health

U.S. Senate Committee on Finance

by

C. Thomas Smith, President, Yale-New Haven Hospital

and Member, Administrative Board, Council of Teaching Hospitals

Edward J. Stemmler, M.D., Dean, University of Pennsylvania

and Chairman, Administrative Board, Council of Deans

October 1, 1984

aamc

Association of American Medical Colleges / One Dupont Circle, N.W. / Washington, D.C. 20036 / (202) 828-0490

The Association of American Medical Colleges welcomes the opportunity to testify at this hearing on medical education funding by the Medicare program. As requested by Subcommittee staff, this statement describes present arrangements for financing both undergraduate and graduate medical education. In financing undergraduate or pre-MD medical education (UGME), Medicare assists medical schools only by paying faculty physicians for professional medical and surgical services provided directly to Medicare beneficiaries. These services are paid on the same fee-for-sevice basis Medicare uses to pay physicians generally. In financing graduate medical education (GME), or residency training, Medicare plays a significant role through the payment of the direct medical education passthrough and the increased payment of the resident-to-bed adjustment.

The AAMC, which represents all of the nation's medical schools, 73 academic societies, and over 350 major teaching hospitals participating in the Medicare program, is vitally interested in all aspects of medical education in the United States. If future generations of Americans are to have appropriate access to well-trained physicians, we must continue to maintain and strengthen our medical education system, including its residency training component. Moreover, we must maintain the capabilities and strengths of our system in the face of dramatic changes in the environment faced by teaching hospitals, medical schools and clinical faculty.

I. UNDERGRADUATE MEDICAL EDUCATION

While the focus of today's hearings is the financing of graduate medical education, the Committee has expressed an interest in securing a more general portrait of how medical education is financed, particularly at the undergraduate level. Therefore, the first part of this presentation, intended to complement the one on graduate medical education that will follow, will address the more general financing issue, first from the point of view of the students---how they meet the costs of tuition, supplies and living expenses---and then from the point of view of the medical school.

How Students Finance Their Education

It falls upon medical students to finance, somehow, the tuition and fees charged them as well as their living expenses for four years of undergraduate medical education. From the point of view of the student, medical education is expensive.

Tuition and fees, in terms of national medians, are shown in Figure 1. For 1983-1984, median private school tuition was $12,104, up from $1,050 in 1960-1961; comparable tuitions for public schools are $3,652 and $498. Inflation, other costs, and the policies of state and federal government account for the changes. Clearly the severe inflation experienced in the 1970's is important. But even after adjusting for inflation, the real increases from 1960-1961 to 1983-1984 were 340% and 220%, respectively, for private and public schools. The public schools, whose tuitions have always been less than

those of the private schools, have by policy maintained low tuition charges. Since the costs of education are basically the same in both public and private institutions, the difference between the tuition levels in these genres of schools can be thought of as a partial scholarship for the students enrolled in state schools. When capitation awards began to decline sharply in the late 1970's, private schools increased tuition by an amount about equivalent to the lost Federal subsidy (Figure 2).

Although a number of loan and, to a lesser extent, scholarship programs are available to medical students, the current costs of medical education threaten to make it difficult for any but those from wealthy families to aspire to careers in medicine.

Living expenses have by and large reflected general economic conditions. Based on the annual AAMC survey, these have risen in the last seven years from an average of $2,376 in 1976-1977 to $7,098 in 1983-1984.

Funding of Costs.

In general, students fund their education costs through "out-of-pocket" expenditures, scholarships or borrowing.

Non-borrowing. A small and diminishing fraction of seniors---26% in 1979 and 12% in 1984---reported no debt at the time of graduation. This group includes those whose total educational costs were derived from their personal or family resources, from Armed Forces or National Health Service Corps scholarships, or from other scholarship funds. The available sources and magnitude

of scholarship funds are shown in Figure 3. Non-service contingent Federal scholarship money, for students in exceptional financial need, has always been small and is shrinking even further, both in real and absolute terms.

Borrowing. At the time of graduation a large and growing fraction of seniors---74% in 1978 and 88% in 1984---report debt incurred for educational purposes. Borrowed funds are derived, as shown in Figure 3, from a number of sources:

- o from conventional private sources, to a small extent;
- o from private sources, under Federal guarantee, through the relatively low cost Guaranteed Student Loan (GSL) program, and through the higher cost (91 day Treasury Bill plus 3.5% interest rate plus 2.0% insurance premium per year) Health Education Assistance Loans (HEAL);
- o from the matching revolving funds, established jointly with Federal and school resources, under the National Direct Student Loan (NDSL) and Health Profession Student Loan (HPSL) programs; and
- o from the loan funds accumulated by the schools themselves.

The most recent patterns of usage of the aid portfolio available to medical students are depicted in Figure 4.

- o By far the most important assistance program for medical students is and has been the Guaranteed Student Loan (GSL) Program, which provided over $183 million to 38,608 students in 1982-1983. This program

reached 58.3% of the undergraduate population and supplied 40.5% of all medical student aid. The average GSL was about $4,750.

- The Health Education Assistance Loan (HEAL) Program, which offers market-rate, interest-compounding loans of up to $20,000/year, is rapidly expanding and is now the second largest loan program for medical students. In 1982-1983, just over $50 million was borrowed to originate 6,554 HEAL's at an average size of $7,695.

- Health Professions Student Loans (HPSL) supplied $24.9 million in 1982-1983, providing an average loan of $2,103 to 9,551 students.

- National Direct Student Loans (NDSL) dispersed $14.9 million in 1982-1983.

- The National Health Service Corps program of service-contingent Federal scholarship programs has been diminishing in size. Only 1,556 students were able to avail themselves of the program in 1982-83.

- The Armed Forces Health Professions Scholarships program has steadily increased in dollar terms; 3,171 students used this option last year.

- General scholarship funds for medical students are limited.

Student Debt.

Since the spring of 1979, the AAMC has conducted an annual survey of graduating seniors. One item on which data is collected is the existence and magnitude of debt. In the last five years, as shown in Figure 5:

- mean debt has about doubled---$15,663 to $26,496;
- the fraction of students whose debt exceeds $30,000 has almost tripled---11% to 32%; and
- the fraction of students whose debt exceeds $50,000 has more than quintupled---1.5% to 8.1%.

How Medical Schools Are Financed

By way of preface, it should be emphasized that the modern medical school, as a result of the profound changes in societal attitudes, economic conditions and political views that have occurred during the last 40 years, is very different from its pre-World War II ancestor.

- When, in the late 1940's, a national policy to mount and maintain a very large biomedical research program was ratified, the medical schools, in the aggregate, assumed responsibility for over half of that effort, with a concommitant major expansion in faculty.

- When a national policy was adopted that expanded access to care for the aged and the poor, the traditional medical school function of providing care for the medically indigent had to be changed, since the size of that group had been reduced. As a result of fundamental changes in the financing of medical care wrought by Medicare, Medicaid and the burgeoning of private health care financing mechanisms, the expanded need to recruit private patients for teaching stimulated a responsive reorganization of clinical functions, and a substantial expansion of clinical faculty.

- As research achievements opened new horizons for care, and as access to care was expanded, it became imperative for the schools not only, through graduate medical education programs, to train more medical specialists and subspecialists, but also to participate in the training of other health professionals---dentists, nurses, pharmacists, allied health specialists.

- All of these forces accelerated the evolution of medical institutions into what are now called academic medical centers, with the medical school as a key component, along with teaching hospital(s), schools of dentistry, public health, pharmacy, nursing, allied health and other types of health-oriented institutions.

In any discussion of medical school financing, it is essential to recognize that the function of these institutions and their faculties is no longer simply to produce physicians. Other faculty activities yield: an extensive array of medical specialists and subspecialists and of other health professionals; a steady flow of basic and clinical research results; frequent contributions to technological developments and improvements; a large volume of medical service, in both inpatient and outpatient settings; and a host of other, including community outreach, activities. Virtually all individual faculty members are engaged in multiple functions. Moreover, they usually perform several of these functions at the same time and thereby make the costing of any single function, e.g., undergraduate medical education, subject to

the classic ambiguities of joint simultaneous production functions. The revenue streams of the medical schools should be analyzed with this background in mind.

Medical School Revenues.

Medical schools derive income from both government and non-government sources for the operation of programs in education, research and patient care. About 38% of this is earmarked for sponsored or restricted programs, with the remainder available for general operations. Summary data on these revenue streams in both current and constant dollars, is shown in Figures 6A through 6D. Aggregate revenue is large, exceeding $8 billion in 1982-1983; this amounted, on the average, to $60.4 million for each public, and $74.4 million for each private, school. Beside this total income, that from tuition pales into insignificance. Several of these revenue streams warrant explicatory comment.

Federal research awards are a major source of revenue for medical schools. These funds must, of course, be used only for research and faculty members must devote at least as much time and effort to research as they derive reimbursement from the research award; they cannot be used to subsidize undergraduate medical education. In 1982-1983, 16.7% of public and 24.5% of private school revenues---and equal and off-setting expenditures---were derived from Federal research awards. Activities supported through these

funds have, over the last several decades, contributed enormously to the exciting intellectual ambiance of U.S. medical schools, as the frontiers of knowledge have been steadily and relentlessly pushed back.

Other Federal income includes awards under Federal training, education and service programs and, principally, reimbursements for expenditures incurred for indirect costs on Federally sponsored programs.

State and Local Government. Public schools derive a substantial (36%) amount of their revenues from government sources. Most of this is through the regular appropriations for state educational institutions and is, to variable degrees, subject to expenditure limitations. Some states provide small subsidies to private medical schools, accounting for about 4% of the aggregate income of these institutions.

Tuition and fees account for about 6% of medical school revenues, 3% for public, and 9% for private, schools. This income is generally believed to constitute a relatively small fraction of the cost of the undergraduate medical education program. In 1974, two studies on the average annual cost per student were completed, one by the Institute of Medicine under Congressional mandate, the other by an AAMC Committee. Giving due weight to certain differences in methodology, the studies reached highly concordant conclusions. The median tuitions at that time, of about $2,400 for private, and $800 for public, schools covered only 10% to 20% of the estimated costs. The expense

of conducting program cost studies, in terms of both fiscal outlays and faculty energies, is high; therefore, there has been no subsequent systematic production of program cost data. However, tuition probably supports no larger a fraction of undergraduate educational costs today than in 1972. The shortfall must, therefore, be recovered from other revenue sources.

Even though tuition is a relatively small component of medical school income and covers a relatively small fraction of educational program costs, it is probably the largest source of flexible funds for discretionary expenditure, and, at least in the case of private schools, is thus highly valuable to them.

Medical Service. The medical service revenues come principally from professional fees generated by faculty members from their patient care activities. In addition, affiliated hospitals reimburse medical schools for that part of a faculty member's time and effort devoted to activities that are essentially hospital specific. In 1982-1983, this source accounted for 26.5% of the gross revenues of the public, and 36% of the private, schools.

Trends in Medical School Revenues.

Over an extended epoch, the relative importance of the several revenue streams has changed, as shown in Figure 7.

- Federal sources, principally research, accounted for more than 40% of all revenues from 1960-1961 until the early 1970's, reaching a peak of over 50% in the mid-60's; subsequently, the Federal share fell to

about 25%. Federal research revenues paralleled national appropriations for biomedical research, whose growth slowed dramatically in the mid-60's. Federal manpower expenditures---and medical school revenues therefrom---including capitation awards, after a meteoric rise in the mid-60's, declined precipitously as public and Congressional concerns over a physician shortage became less urgent.

- o Tuition income, while increasing in both current and constant dollars, remained a relatively small and steady source of income.

- o State and local government contributions have increased both absolutely and relatively. This is attributable to the fact that the lion's share of the recent expansion of medical school capacity was under the aegis of the states.

- o Revenue from medical service is the most rapidly growing source of income for the schools. This may be in part artifactual: as the two class system of health care disappeared, the medical school adjustments in the post 1965 years included the creation of faculty practice plans, under which faculty service income was for the first time formally recorded as medical school revenue. But it is also undoubtedly true that shrinking revenues from other sources---principally Federal, and principally for research and education---have required faculty members to devote an increasing fraction of their efforts to earning more of their salaries through patient care activities.

II. GRADUATE MEDICAL EDUCATION

Our present system for graduate medical education and its financing has much to commend it. Nevertheless GME rests upon a relatively fragile interweaving of multiple institutional capabilities, individual goals, foregone compensation, and personal initiative. It is a system that could be easily damaged unless any changes to it are carefully crafted and based on an extensive understanding of both the nature of the teaching hospitals in which GME is carried out and the nature of graduate medical education itself.

Contemporary American teaching hospitals are among our nation's most complex enterprises. In addition to the basic hospital services of primary and secondary inpatient care, teaching hospitals provide the bulk of the nation's tertiary care for the most seriously ill; regionalized special care and stand-by services; clinical training of physicians and other health care personnel; access to medical services for disproportional numbers of the poor and medically indigent; and the development and testing of new diagnostic and treatment servies. Significantly, these multiple products are not independently provided in separate corporate divisions. Rather, the teaching hospital's added responsibilities are generally fulfilled in a single organization with multiple, interrelated objectives. As this hearing considers one of the special responsibilities of teaching hospitals, graduate medical education, the AAMC must note that the future of teaching/tertiary care hospitals rests on adequate societal support of all these specialized functions.

Contemporary Graduate Medical Education

Graduate medical education is the phase of formal medical education that begins at graduation from medical school and ends after the educational requirements for one of the medical specialty certifying boards have been completed. The term 'residency' is commonly used to describe the period of graduate medical education.

Graduate medical education has become as important as undergraduate medical education in the preparation of physicians. It has evolved from a short period of practical experience in a hospital into a formalized, structured educational program, the completion of which is necessary for physicians to be capable of practicing medicine at a level consistent with current knowledge and technology and anticipated developments. In the 1980s, over 17,000 students will graduate annually from the 127 medical schools accredited by the Liaison Committee on Medical Education. The vast majority will spend three to seven years as residents in graduate education.

As reported in the current issue of the ACGME Directory of Residency Training Programs, there were 72,397 residents in GME on September 1, 1983. This training was provided in a total of 1,530 institutions, the vast majority of which were hospitals. While simple division would suggest an average of 47 residents per training institution, this is misleading. The 100 non-Federal AAMC member hospitals with the largest residency programs were training 46% of the total residency complement (Figure 8). Thus, while a large number of hospitals

(and some other agencies) are involved in residency training, less than two percent of all hospitals train nearly one-half of all residents.

The Directory of Residency Training Programs presently lists accredited residency programs in 36 specialty programs. The Directory's tabulation shows, however, that 60% of all residents are training in five fields of specialization (Figure 9): internal medicine (24.3%), general surgery (10.9%), family practice (10.0%), pediatrics (8.5%), and obstetrics/gynecology (6.4%). These are the specialties that most Americans use for primary medical and surgical care.

It should also be noted that 55% of residency training takes place in eight states: New York, California, Pennsylvania, Texas, Illinois, Ohio, Massachusetts, and Michigan. These states contain 47% of the population according to the 1980 census (Figure 10).

The key conclusion from a review of residency program size, concentration of specialties, and location of training is clear: while the majority of residents are concentrated in a small number of hospitals, specialties, and states, the remaining residents are widely distributed. With this heavy concentration but broad dispersion, public policy makers must carefully consider the impact of proposed policies on both the large concentrations as well as the broader distribution.

Financing Graduate Medical Education

Under the present system of graduate medical education, residency training is financed primarily by patient service revenues, most particularly by payments of hospital charges and reimbursement. For example, Figure 11, from the AAMC's

1983 survey of stipends paid to housestaff, shows 83% of the stipends are paid from hospital patient revenue when Federal hospitals are excluded. The next largest source, state appropriations, supports only 6% of residents' stipends. For advanced residents, called clinical fellows, the role of hospital revenues is somewhat smaller, but still accounts for over 60% of funding. While residents' stipends are only one major cost of these programs, the AAMC believes the importance of hospital revenue is characteristic of the total costs as well.

The data presented in Figure 11 exclude Federal hospitals, both Veterans Administration and military. A significant number of residents train in these hospitals with the VA alone training approximately 12% of all residents. Funds for these residents are provided to VA and military hospitals as a part of their Federal appropriation. In addition, a limited amount of Federal support for residency training in general internal medicine and pediatrics and family practice is available from the Public Health Service. In FY 1983, $45 million was appropriated for these grants. A number of states also provide special funding for family practice residencies. Thus, Federal and state appropriations provide only a highly limited source of funding for GME.

To obtain the necessary revenues, non-Federal teaching hospitals include residency program expenses in setting charges and determining reimbursable costs. The present Medicare program presents an excellent example of how this practice works to support graduate medical, nursing, and allied health education.

Medicare Payments

Direct Medical Education Costs

To provide clinical training for residents, nurses, and allied health personnel, hospitals incur costs beyond those necessary for patient care. Since its inception, Medicare has paid its share of these added direct expenses on a cost reimbursement basis. Under prospective payment, cost reimbursement for these expenses is continued using the "direct medical education passthrough."

The justification for this passthrough was clearly discribed in the Secretary's 1982 report Hospital Prospective Payment for Medicare (pp 47-48):

> The Department believes that the direct costs of approved medical education programs should be excluded from the rate and be reimbursed as per the present system. This approach will assure that the base rate is related to a patient care outcome and not significantly influenced by factors whose existence is really based on objectives quite apart from the care of particular patients in a particular hospital.

Congress supported the Department's position that it was not appropriate to include clinical training costs in the DRG payment and approved continuing to pay the added costs of graduate medical education on a cost reimbursement basis separate from the DRG based per case payment.

Medicare's share of the direct medical education passthrough is determined using generally accepted accounting principles and Medicare reimbursement regulations. The hospital accounting system accumulates expenses directly

associated with these activities in specific cost centers. For example, hospital expenses for resident stipends are recorded in the graduate medical education (or intern and resident) cost center. After all expenses are entered, overhead expenses -- such as administration, maintenance, and utilities -- are allocated (or apportioned) across the Medicare recognized cost c[illegible]ch as graduate medical education. Thus, the cost being reimbursed through the direct medical education payment includes expenses incurred by that cost center and allocated overhead.

"Indirect Medical Education Adjustment"

In 1980, the then-effective Medicare routine service limits included a passthrough for GME costs. An HHS analysis showed that, even with the passthrough, teaching hospitals were disproprotionately penalized by the limit. Further HHS studies revealed that the likelihood of being penalized was directly related to a teaching hospital's ratio of residents to beds. Using these findings, HCFA modified the limit to include a resident-to-bed adjustment for the costs found to be statistically associated with graduate medical education.

The initial adjustment was set at 4.7% for each 0.1 resident per bed. When the routine limits were replaced by the more-inclusive TEFRA limits, the residents-to-bed adjustment was retained but recalculated at 6.06% for every 0.1 resident per bed. As is described below, the resident-to-bed adjustment was retained for prospective payent but increased to 11.59% for every 0.1 resident per bed.

As Congressional committees considered the proposed Medicare prospective payment system early in 1983, the Congressional Budget Office (CBO) prepared estimates of the impact of the new payment system on different types of hospitals. Hospitals were compared on the basis of region, urban/rural location, bed size, ownership and teaching status. CBO estimates showed that teaching hospitals would suffer disproportionate revenue losses under the proposal and that the amount of the loss would be relatively greater for hospitals with at least .25 residents per bed than for hospitals with lower resident-to-bed ratios. In anticipation of this relationship, the Secretary's report on Hospital Prospective Payment for Medicare proposed an adjustment in DRG payment rates based on the ratio of residents-to-beds in teaching hospitals (pp 48-49).

> The indirect costs of graduate medical education are higher patient care costs incurred by hospitals with medical education programs. Although it is not known precisely what part of these higher costs are due to teaching (more tests, more procedures, etc.), and what part is due to other factors (the particular types of patients which a teaching hospital may attract), the Medicare cost reports clearly demonstrate that costs per case are higher in teaching hospitals.
>
> It is also clear that the mere presence of interns and residents in an institution puts extra demands on other staff and leads to the existence of higher staffing levels. The process of graduate medical education results in very intensive treatment regimens. Again, the relative importance of the various reasons for the higher costs observed in teaching hospitals is difficult to identify precisely. However, there is no question that hospitals with teaching programs have higher patient care costs than hospitals without.
>
> The Department believes that recognition of these indirect costs should be accomplished through a lump-sum payment, separate and distinct from the base rate. This adjustment will be computed using methods that are similar to the methods currently used to adjust the old routine and new total cost limits for the indirect costs of graduate medical education. The hospital's cash flow will be preserved by some sort of periodic payment.

Because the Department's proposed adjustment did not provide equitable treatment for tertiary care/teaching hospitals, Congressional committees asked CBO staff to estimate prospective payment impacts using a doubling of the Department's proposed adjustment. The resulting estimates showed teaching hospitals would be benefited or penalized under the new sytem in approximately the same proportion as non-teaching hospitals. Thus, a doubling of the proposed resident-to-bed adjustment provided the desired equity between teaching and non-teaching hospitals.

Congress, and most particularly this Committee, clearly recognized the multiple deficiencies the adjustment would help correct.

> This adjustment is provided in the light of doubts ... About the ability of the DRG case classification system to account fully for factors such as severity of illness of patients requiring the specialized services and treatment programs provided by teaching insititutions and the additional costs associated with the teaching of residents ... The adjustment for indirect medical education costs is only a proxy to account for a number of factors which may legitimately increase costs in teaching hospitals. (Senate Report 98-23, p. 52)

In the AAMC's judgment, the resident-to-bed ratio serves as a proxy to adjust for inadequacies in prospective payment, including:

- inadequate recognition of differences within a DRG of the complexity of disease, intensity of care required and resources utilized for patients in the teaching hospitals;

- no recognition for the teaching hospital's costs of maintaining both a broader scope of services and the capacity to provide specialized regional services;

- failure of the wage adjustment to account for differences between central city and suburban wage rates within metropolitan areas;
- decreased productivity which results from including trainees in the hospital programs; and
- additional ancillary services ordered by trainees involved in the diagnosis and treatment of patients.

Thus, while the resident-to-bed adjustment is called the "indirect adjustment for costs accompanying medical education," it is, in fact, a proxy measure to provide appropriate compensation for the added patient service costs borne by teaching hospitals. Nevertheless, its "medical education" label permits the adjustment to be viewed as an educational payment rather than a correction for statistically consistent differences in cost between teaching and non-teaching hospitals. The AAMC is concerned about this misperception and has commissioned HCFA's former research director, Judith Lave, Ph.D., to prepare an objective review and critique of the adjustment. When her paper is finished, we would be pleased to share it with this subcommittee and its staff.

Vulnerabilities and Benefits

Medicare's participation in the financing of graduate medical education faces several challenges. First, to preserve budget neutrality, any special funding for the multiple missions of teaching hospitals reduces the general patient care payment rate for all hospitals, both non-teaching and teaching. Since most hospitals are non-teaching, some do not support this reduction in the general payment rate. Secondly, teaching hospitals vary in the intensity of

their medical education activities. Teaching hospitals with small residency programs have less at stake than teaching hospitals with major programs. In addition, because the indirect adjustment uses residents as a proxy for a variety of cost differences, teaching hospitals with similar patient characteristics but with differences in resident ratios are paid different amounts. Teaching hospitals with comparatively few residents but with patients and costs similar to large teaching hospitals may believe they are not being adequately compensated. Lastly as Congress considers options to reduce the deficit, payments identified with medical education may be more vulnerable than payments for patient care.

Because of these vulnerabilities, two benefits of the present Medicare system should be acknowledged. First, Medicare regulations define residents caring for inpatients as a hospital cost. Therefore, residents are not allowed to bill Medicare on a fee basis for professional services. This is a major savings in Medicare Part B expenditures. For example, in the Tax Equity and Fiscal Responsibility Act of 1982, Congress incorporated in statute the long-standing teaching hospital practice that Medicare patients could not be charged an assistants at surgery fee when a resident is involved in the case unless certain exceptions were met. Similarly, residents performing histories and physicals or administering treatments are not allowed to bill for these services. Thus, while Part A costs are increased to fund residents and their training programs, Part B costs are reduced.

Secondly, while the Medicare program serves primarily today's senior citizens and the disabled, it is financed primarily by taxes paid by the employed. Since Medicare's participation in financing graduate medical education

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helps to ensure that tomorrow's retiree is served by a fully trained physician, GME dollars spent today serve both today's beneficiary and tomorrow's retirees.

While teaching hospitals have greater expenses per admission than non-teaching hospitals, additional products are produced: medical, nursing, and allied health student are trained; new technologies are introduced; and complex patient services are provided. Historically, these added costs have been financed primarily with increased charges and reimbursement using several types of cost shifting:

- patient service revenues have supported graduate medical education,
- routine service revenues have supported tertiary care patients,
- revenues from high volume ancillary services have supported low volume services, and
- payments from paying patients have supported charity care patients

This financing pattern has met the needs of teaching hospitals and the AAMC has supported it. For example, as recently as 1981, an AAMC Task Force on Graduate Medical Education which comprehensively studied GME recommended that, "graduate medical education should continue to be financed from multiple sources, with the principle source being the general operating revenues of teaching hospitals" (emphasis added).

In the new environment of hospitals competing on a price basis and third party payers and health care plans favoring hospitals with low charges, teaching hospitals will not be able to compete unless their special social responsibilities including the educational mission, receive special funding. Payers trying to hold down monthly premiums or limit necessary appropriations are increasingly less willing to pay for GME or any other special cost as a part of health service purchases. While these public and private payers are willing to acknowledge that the GME mission adds costs which are necessary to teaching hospitals, they are not willing to pay for it. Some of them have suggested a special educational subsidy for teaching hospitals.

In its simplest form, developing an educational subsidy involves responding to three questions:

- What is the total funding needed for GME?
- How should the funds be raised?
- How should the funds be distributed?

None of these questions have simple answers.

For example, the most recent edition of an AAMC annotated bibliography on Medical Education Costs in Teaching Hospitals reviews 56 articles on this topic and finds no clear or consistent answer to the question of how large the fund should be. Two things are clear from the bibliography. First, because graduate medical education and patient services are joint products which are simultaneously produced, it is impossible to truly separate and distinguish the input costs of each. Secondly, it is clear that different methodologies ask the

question differently and, therefore, arrive at different answers. Given this situation, Medicare data on the "passthrough" of direct medical education will provide the most up-to-date answer on the costs that can be captured by accounting methods. Payments made using the resident-to-bed adjustment will quantify other consistent cost differences between teaching and non-teaching hospitals.

Moving beyond the three first order questions, a number of important second order issues must be addressed. Recognizing that the intent of this hearing is not to explore or evaluate new approaches, the AAMC does wish to identify the following second order issues which any new proposal must address, including how do alternative methods for financing GME:

- balance a hospital's need for services with a resident's education?
- balance the added costs of the hospital training the resident with the benefits accruing to the group, health plan, or hospital eventually employing the then trained physician?
- balance the educational objective of a centralized educational funding organization with decentralized patient competition of the hospital providing the training?
- affect the specialty distribution of residents?
- affect the geographic distribution of residents? and

- affect the ability of providers other than acute care hospitals to participate in residency training?

When examined along these dimensions, the current financing system has a number of strengths. To date, patient service revenue has provided a dependable source of funding. This is important for programs with a three to seven year duration. Residents want and deserve a reasonable assurance that the program they enter will still be strong when they are finishing. Secondly, hospitals have been able to develop residency programs that complement and support the hospital's patient care programs. Third, because direct operating costs have been paid on a cost basis, professional judgments on the balance of patient care service and education activities have not been influenced by financial incentives. Fourth, because the financial requirements of graduate medical education have been met, a small number of teaching hospitals have trained physicians who go on to serve other communities and hospitals. Finally, the stability of the financing system has enabled accreditation agencies to realistically assume a stability of the residency's quality.

The present financing system, however, does have its weaknesses. First in an increasingly price competitive market for hospital services, hospitals having higher patient charges to support special missions are at a disadvantage. Secondly, the present financing arrangement has worked better in inpatient services than in outpatient services or in non-hospital training sites. As a result, specialties emphasizing inpatient care have been favored over those emphasizing ambulatory care. Training in the surgical specialties has been advantaged relative to training in general primary care. Third, reimbursed on a

cost basis, hospitals have been unable to effectively challenge specialty board efforts to increase the length of residencies and to develop an increasing number of subspecialty programs. Finally, because payroll taxes are used for the Part A trust fund, graduate medical education is supported with a relatively regressive tax.

These strengths and weaknesses of our present system are known. Additional information for use in assessing the present system and alternative arrangements is presently being developed in at least three studies:

- the HHS Assistant Secretary for Planning and Evaluation's study of the Financing of Graduate Medical Education being performed by Arthur Young and Company,
- the Commonwealth Fund Task Force on Academic Medical Centers is preparing an analytical paper on "The Future Financing of Teaching Hospitals" using a secondary analysis of existing data; and
- the Health Care Financing Administration will be preparing four annual reports on the impacts, intended and unintended, of prospective payment on types of hospitals, including teaching hospitals, and

In addition, the AAMC recently convened the initial meeting of its Committee on Financing Graduate Medical Education chaired by J. Robert Buchanan, M.D., General Director, Massachusetts General Hospital to explore and evaluate current payment arrangements. Alternative findings and recomendations from each of these efforts should assist this Subcommittee in describing and evaluating the financing of medical education.

Conclusion

In this statement, undergraduate and graduate medical education have been presented as more sharply separated and independent than, in reality, they are. Moreover, the degree of their interdependency, not only on each other but also on other health professional educational programs, on basic clinical biomedical research, and on exemplary patient care in a highly complex and highly integrated environment, has not been given the explicit emphasis it deserves. Nowhere more than in the teaching hospital can the intense and concurrent pursuit of these multiple functions be witnessed more impressively. Modifications of specific functions rarely have isolated effects but almost immediately exert influence over most if not all other funcitons.

To remain fiscally viable, medical schools have had to adjust to substantial changes in revenue sources over which they have relatively little control. As additional constraints are placed on the sources of their funds, these institutions are fining it increasingly difficult to accommodate, without serious distortion, their multiple services of education, research and patient care.

The American system for graduate medical education is grounded in the teaching hospital. Graduate medical education cannot function effectively unless teaching hospitals are compensated for the added costs associated with their responsibility. For the last two decades, the financing of teaching hospitals has been adequate and stable and GME programs have trained thousands of competent physicians annually. As medical schools responded to a national policy of increasing physician graduates, hospitals responded by expanding residency

training. Now, however, the financial stability of teaching hospitals is at risk. Some new payment systems are based on an assumption that a particular inpatient type should have the same costs in all hospitals with payers increasingly unwilling to support the added costs of GME. In a "prudent buyer," price competitive market, tertiary care/teaching hospitals will fail financially because paying an average price per case does not meet the financial requirements of the teaching hospital's special services. Even a subsidy for graduate medical education will be insufficient if it does not include additional expenses for tertiary care services, stand-by services, new technology, and charity care in addition to graduate medical education.

Teaching hospitals are a diverse group of highly complex institutions performing medical education and research services for the nation and providing both basic and tertiary patient care. The current emphasis on re-examining national policies in light of more limited public resources places teaching hospitals and their vital activities at significant risk if their special nature and role are not appreciated. As policies and expectations change, teaching hospitals will continue to adapt and evolve. If developing national policies on health care delivery and payment recognize the distinctive characteristics and diversity of teaching hospitals, their fundamental missions can be preserved. If the characteristics of teching hospitals are not recognized and valued, simplistic public policies may damage the ability of these institutions to fulfill their multiple responsibilities. The Association is pleased that this Subcommittee and its chairman appear willing to study all of these issues before embracing proposed solutions.

FIGURE 1

U.S. MEDICAL SCHOOL MEDIAN TUITION AND FEES FOR FIRST-YEAR MEDICAL STUDENTS 1960-61 THROUGH 1982-83

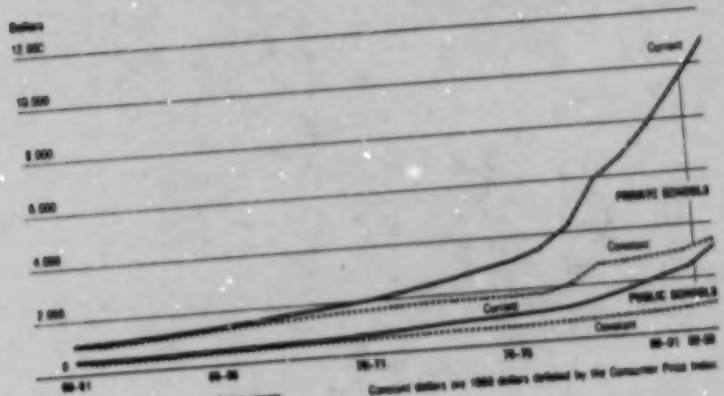

FIGURE 2

Medical School Capitation and Tuition

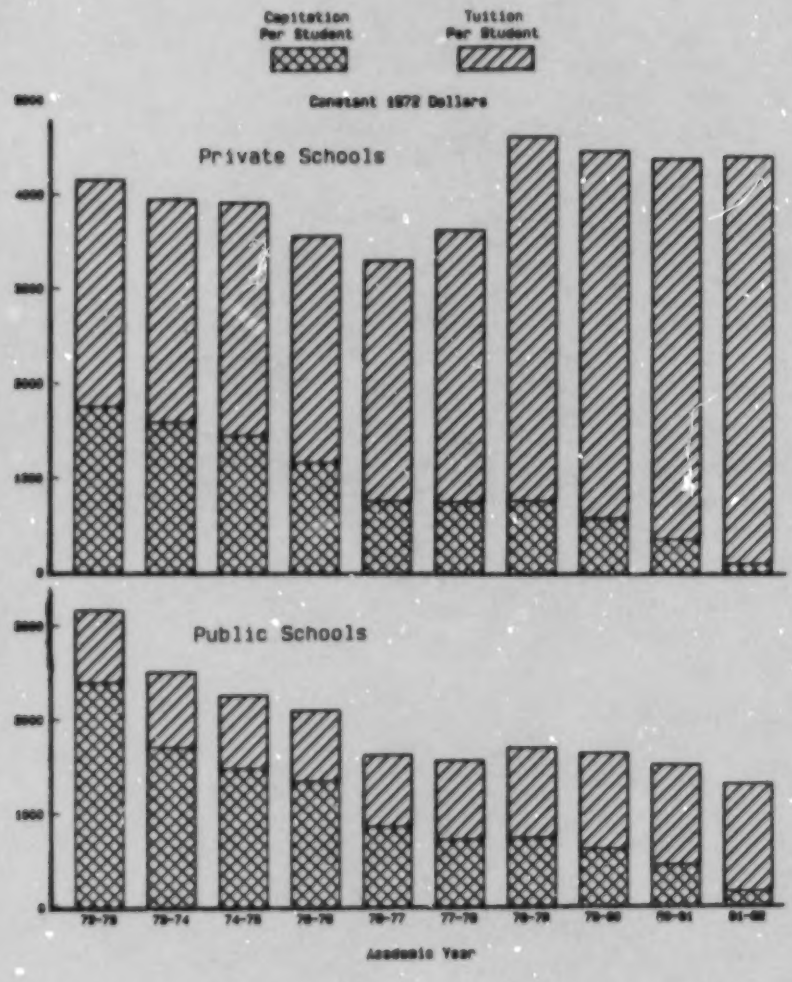

FIGURE 3

SOURCES OF STUDENT FINANCIAL ASSISTANCE, 1974-75 THROUGH 1982-83
(DOLLARS IN THOUSANDS)

	1974-1975	1975-1976	1976-1977	1977-1978	1978-1979	1979-1980	1980-1981	1981-1982	1982-1983
SERVICE CONTINGENT SCHOLARSHIPS	$2,864	67,304	79,043	79,453	104,630	123,471	136,376	143,389	133,890
Armed Forces	14,744	21,013	21,196	24,767	29,608	32,558	38,029	44,810	40,840
National Health Service Corps	8,017	16,625	18,590	25,194	37,932	49,815	50,111	38,721	23,474
Other	15,293	14,798	14,648	11,168	17,046	20,426	25,168	32,849	29,583
OTHER SCHOLARSHIPS	22,885	22,107	23,484	25,299	32,642	37,889	37,128	40,669	50,293
School Funds	14,010	15,068	15,013	18,334	20,044	20,672	23,078	27,180	30,759
Medical Scientist Training Program (MSTP)	-	-	-	-	-	-	-	7,727	7,910
Exceptional Financial Need Scholarship (EFN)	-	-	-	-	2,545	3,551	5,135	4,990	2,449
Other	8,875	7,039	8,811	6,965	10,073	8,466	8,915	9,062	9,174
LOANS	71,882	81,282	95,214	128,162	159,369	213,175	264,885	319,675	286,686
Guaranteed Student Loans	30,700	40,599	50,143	78,957	105,748	150,317	189,344	230,703	114,502
Health Professions Student Loans	21,316	20,077	18,678	18,965	19,756	17,584	22,664	24,348	22,960
Health Education Assistance Loans	-	-	-	-	840	4,299	15,302	33,166	50,436
National Direct Student Loans			2,988	9,301	12,804	17,357	16,041	12,737	14,910
Private Funds	13,581	14,233	15,942	11,212	13,123	15,108	11,434	9,096	5,986
School Funds	5,975	6,373	7,463	7,727	7,298	8,520	9,290	9,625	18,872
COLLEGE WORK STUDY	-	-	-	775	775	1,400	1,441	1,483	1,481

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FIGURE 4

Sources of Medical Student Financial Assistance

Source	1981–82 Total Amount	1981–82 Number	1981–82 Average Amount	1982–83 Total Amount	1982–83 Number	1982–83 Average Amount
Scholarships						
Administered by schools						
Exceptional financial need	$ 4,899,584	418	$11,721	$ 2,468,861	172	$14,238
Medical Scientist Training Program	7,726,683	710	10,882	7,910,675	662	11,950
School funds	27,188,407	11,418	2,380	30,799,501	13,397	2,313
Other scholarships	9,062,014	6,248	1,450	9,174,466	6,283	1,460
Subtotal	48,866,690			50,393,503		
Not administered by schools						
Armed Forces health professions	44,889,664	3,263	13,753	48,840,830	3,171	15,402
National Health Service Corps	30,720,794	2,582	13,435	23,474,483	1,556	15,086
National medical fellowships	912,380	766	1,191	682,610	730	935
Other (with service commitment)	10,999,568	2,196	4,990	9,719,366	1,824	5,329
Subtotal	95,482,396			82,716,489		
Total Scholarships	144,370,986			133,089,912		
Loans						
Administered by schools						
Health professions loans	24,347,510	10,245	2,376	22,949,645	9,551	2,403
Guaranteed student loans	13,775,156	2,605	5,287	4,709,462	984	4,786
National direct student loans	12,737,613	7,216	1,765	14,949,736	8,057	1,851
Loans from school funds	9,634,746	6,383	1,531	16,822,076	7,695	2,344
Subtotal	60,494,823			59,380,919		
Not administered by schools						
Guaranteed student loans	214,923,626	43,899	4,985	176,136,648	37,634	4,745
Health education assistance loans	33,166,499	4,701	7,055	58,436,252	6,554	7,695
PLUS loans	2,884,325	752	2,665	11,256,451	3,930	2,864
Other loans	9,891,526	3,678	2,672	3,986,290	2,476	2,418
Subtotal	259,109,378			246,215,641		
Total loans	319,674,201			305,686,560		
College Work Study Program	1,482,911	1,274	1,163	1,481,763	1,092	1,284
Grand Total	465,438,098			440,018,035		

FIGURE 5

Debt Status of Senior Medical Students

1978-79 TO 1983-84

Year	Percent of Seniors with Debt	Mean Debt Of Seniors with Debt	Percent of Indebted Seniors with Debt Over $30,000	Percent of Indebted Seniors with Debt Over $50,000
1978-79	74%	15,663	N/A	N/A
1979-80	77%	17,212	11.4%	N/A
1980-81	77%	19,697	14.5%	1.5%
1981-82	83%	21,051	18.4%	2.9%
1982-83	86%	23,647	24.7%	4.7%
1983-84	88%	26,496	31.6%	8.1%

Source: AAMC Graduation Surveys

FIGURE 6A

Trends in U.S. Private Medical School Revenues

(millions of dollars)

Revenue Source	1967-68 Amount	1967-68 Percent	1972-73 Amount	1972-73 Percent	1977-78 Amount	1977-78 Percent	1982-83 Amount	1982-83 Percent
Federal Research	264	42.1	416	37.4	588	29.5	886	24.5
Other Federal	79	12.6	106	9.5	157	7.9	187	5.1
State and Local Gov't	32	5.1	90	8.1	108	5.4	159	4.3
Tuition and Fees	33	5.3	63	5.7	162	8.1	336	9.1
Medical Service	91	14.5	172	15.5	609	30.5	1,426	39.1
Other Income	127	20.3	264	23.8	371	18.6	655	17.9
Total	627	100.0	1,111	100.0	1,995	100.0	3,647	100.0

FIGURE 6B

Trends in U.S. Public Medical School Revenues (continued)

(millions of dollars)

Revenue Source	1967-68 Amount	1967-68 Percent	1972-73 Amount	1972-73 Percent	1977-78 Amount	1977-78 Percent	1982-83 Amount	1982-83 Percent
Federal Research	190	34.6	296	27.7	443	18.7	759	16.7
Other Federal	71	12.9	137	12.8	155	6.5	229	5.1
State and Local Gov't	151	27.5	332	31.0	914	38.6	1,629	35.9
Tuition and Fees	15	2.7	29	2.7	69	2.9	147	3.2
Medical Service	63	11.5	135	12.6	509	21.5	1,282	28.5
Other Income	59	10.7	140	13.1	282	11.9	564	12.4
Total	549	100.0	1,070	100.0	2,372	100.0	4,531	100.0

FIGURE 6C

Trends in U.S. Private Medical School Revenues

(constant 1967 dollars* in millions)

Revenue Source	1967-68 Amount	1967-68 Percent	1972-73 Amount	1972-73 Percent	1977-78 Amount	1977-78 Percent	1982-83 Amount	1982-83 Percent
Federal Research	264	42.1	329	37.4	332	29.5	342	24.5
Other Federal	79	12.6	84	9.6	88	7.9	71	5.1
State and Local Gov't	32	5.1	71	8.1	61	5.4	61	4.3
Tuition and Fees	33	5.3	50	5.7	92	8.1	128	9.1
Medical Service	91	14.5	136	15.5	344	30.5	544	39.1
Other Income	127	20.3	209	23.8	210	18.6	250	17.9
Total	627	100.0	878	100.0	1,128	100.0	1,392	100.0

FIGURE 6D

Trends in U.S. Public Medical School Revenues (continued)

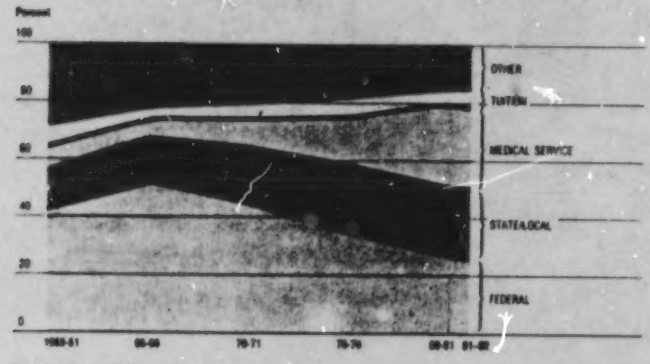
(constant 1967 dollars* in millions)

Revenue Source	1967-68 Amount	1967-68 Percent	1972-73 Amount	1972-73 Percent	1977-78 Amount	1977-78 Percent	1982-83 Amount	1982-83 Percent
Federal Research	190	34.6	234	27.7	250	18.7	290	16.7
Other Federal	71	12.9	108	12.8	88	6.5	87	5.1
State and Local Gov't	151	27.5	262	31.0	517	38.5	622	35.9
Tuition and Fees	15	2.7	23	2.7	39	2.9	56	3.2
Medical Service	63	11.5	107	12.6	288	21.5	459	26.5
Other Income	59	10.7	111	13.1	159	11.9	215	12.4
Total	549	100.0	846	100.0	1,341	100.0	1,729	100.0

* Constant dollar calculations are based on the GNP deflator.

FIGURE 7

DISTRIBUTION OF SOURCES OF REVENUE FOR MEDICAL SCHOOLS
1960-61 THROUGH 1981-82



Source: Association of American Medical Colleges

Figure 8

CONCENTRATION OF RESIDENTS, 1983

HOSPITAL GROUP	% OF RESIDENTS	AVERAGE HOUSESTAFF
National Average 1530 Hospitals, Agencies	100%	47
Largest 50 COTH	29	425
Second 50 COTH	17	239

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Figure 9

PERCENTAGE OF RESIDENTS, BY SPECIALTY (1983)

RESIDENCY	PERCENT	CUMULATIVE
Internal Medicine	24.3%	24.3%
General Surgery	10.9	35.2
Family Practice	10.0	45.2
Pediatrics	8.5	53.7
OB/GYN	6.4	60.1
All Others	39.9	100.0

Figure 10

COMPARING RESIDENTS AND POPULATION

STATES	% of RESIDENTS	% of POPULATION
New York	14.7%	7.8%
California	9.6	10.9
Pennsylvania	6.4	5.2
Texas	5.7	6.7
Illinois	5.6	5.1
Ohio	5.0	4.8
Massachusetts	4.1	2.6
Michigan	4.1	4.0
TOTAL	55.2%	47.1%

Figure 11

Percentage Distribution of Funding Sources Used to Pay Hospital Costs of Housestaff Stipends and Fringe Benefits, 1982-1983 Excluding VA Hospitals

Funding Source	Source of Revenue, in Percent	
	Residents	Clinical Fellows
Patient Revenues and General Operating Appropriations	83.09%	62.56%
State Appropriations Earmarked for Housestaff Expenses	6.26	1.03
Municipal Appropriations Earmarked for Housestaff Expenses	1.58	0.95
Veterans Administration Appropriations	1.56	2.78
Physician Fee Revenue	0.47	2.87
Medical School/ University Funds	1.92	6.92
NIH	0.24	9.09
Other Federal Agencies	0.21	1.00
Endowment Income	0.01	0.99
Foundation Grants, Voluntary Agencies	0.30	5.98
Other	4.26	5.82
TOTAL	100.00%	100.00%
Number of Hospitals	215	121

Senator DURENBERGER. Did I correctly state in the beginning that the association just started a committee of some kind?

Mr. SMITH. That's correct.

Senator DURENBERGER. Do either of you want to elaborate on that? I hope it's not like the AMA. They've come in here for 2 years now telling us they are looking at the totality of health care in this country so they can't really give us any advice on anything until they get done with that one.

Mr. SMITH. No. We would expect to provide you with some information. The committee has been formed. It is at work. It is chaired by Dr. Robert Buchanan, president of the Massachusetts General Hospital. I will expect that report will be done with within a year.

Dr. KNAPP. I hope we have something for you in the spring.

Senator DURENBERGER. Of? [Laughter.]

Dr. KNAPP. I hope we are in a position to respond by spring of 1985 one way or the other. Our current position is fairly well straightforward. That the financing ought to come out of the hospital services dollar. It's obvious that we are getting pressure from our own constituents who are concerned about what I will just call brokerage patients on HMO's, PPO's, et cetera. So it isn't only the Medicare situation that is bothersome. You accurately stated it at the front end of this hearing.

It is on the top of the priority list for our activities.

Senator DURENBERGER. For those of you who are expecting a coffeebreak, there won't be one until after 4 p.m. because the Senate has recessed until 4 p.m. Sorry about that.

Is there any problem in the next 2 years with the reimbursement scheme that we have designed, passthrough, for graduate medical education? It is a rather generous passthrough on indirect medical education. Are you OK with that in the next 2 years?

Mr. SMITH. I don't think we know enough to know whether it's generous or inadequate.

Senator DURENBERGER. Do you want to tell us about Yale-New Haven and your 1 year of experience? Have you made a lot of money off this process so far? [Laughter.]

Mr. SMITH. We have not made a lot of money off of this. We have performed satisfactorily, given the changes in the system, which I think are moving in the right direction. So I think it's too early to say whether or not the allowance is sufficient because in year one of the system, as you are aware, the cost base was on 75 percent of Yale-New Haven's costs. Once we get to a national average system, whether then, based on national averages, there is a sufficient allowance through this indirect allowance, remains to be seen. There is a lot of concern about that.

Senator DURENBERGER. Do either of you have an opinion as to what part of the problem we might be able to solve for the average of the so-called heavy or large teaching hospitals if we could come up with a good severity index so that we could reflect better the peculiar case mix of some of our larger teaching hospitals?

Mr. SMITH. Clearly, we have got to come up with some better reflection of severity. I don't think that in itself is going to solve the problem. Multiple approaches will have to solve it. As indicated, there are multiple products. And to address that, I don't think a

single solution is sufficient. We will also have to pay attention to graduate medical education issues.

We also have to pay attention to the matter of charity care, care for those with inadequate resources. All of those will have to come together.

Senator DURENBERGER. I don't know whether you are equipped to respond to the question about what other insurers are doing. I indicated in my opening statement not only a concern but I think a reality that some of the other insurers, including the biggee upon which Medicare modeled its education reimbursement, has now decided that it ought to take care of those who pay their bills first. And in the area of Blue Cross, as one example, there are either through their PPO's or selective purchasing plans of one kind or another—there seems to be an increasing emphasis on paying for what you get and not paying for things you don't get directly, such as medical education. Are either of you in a position to indicate now what some other insurers are doing with regard to payment for medical education?

Mr. SMITH. I can speak about what is happening in Connecticut, Senator. We have not had pressure from other providers directly because a move was made in our State legislature during the past year for an all payer system in the State of Connecticut. As of today, our Commission on Hospitals and Health Care's task force is promulgating a set of decisions as to how that prospective all payers system will be devised. One of the key issues under that system that we are grappling with is how to finance graduate medical education. There is an acknowledgement that it's an important problem and an apparent willingness to deal with the problem. Whether it is dealt with sufficiently remains to be seen.

Mr. STEMMLER. I would like to comment, Mr. Chairman, just from the perspective of an educator looking at these changes which are either happening or proposed to happen with respect to the investment in human capital, which is our responsibility in education. And you posed a question previously to Dr. Graham about what is the immediate reward.

And it strikes me that higher education generally, that the investments we make and must preserve with respect to the education of physicians will not reflect itself in terms of rewards for many years to come. And we are very concerned about the moves that are made in the short term for short-term gains in controlling costs. That might harm a system that is so important to the American public.

Senator DURENBERGER. Now there are things that concern some people about the all payers kind of an approach—I can see where it would be of great comfort to an administrator of a hospital. I won't ask you whether it's a great comfort to you or not.

The concern, obviously, is with the fact that it is pointed out in somebody's statement today—and I apologize for not being able to distinguish all your statements, but there are a lot of excellent presentations. But somebody points out the fact that under the current system the people who live where doctors are being educated are the ones who pay for the education. It isn't the people that eventually those doctors will serve.

Now if a doctor goes to the University of Pennsylvania for graduate medical education, the teaching hospital there, and ends up going to Utah or southern California or Minnesota or some place like that, if, in fact, you are correct in all the statistics in here, that 83 percent of the costs of graduate medical education are patient revenues, then that theory seems to be incorrect. That the folks served by the University of Pennsylvania are paying for that education. Not the people out in Utah or Minnesota or some other place. Is that a fairly correct statement?

Dr. STEMMLER. Well, I would not agree with you as you formulated that in this sense, Senator. We at least like to look beyond the immediate payor to the base on which the payments are collected through participation by the general public, either directly or through their employer in creating the base of funds that in an actuarial sense is used to defray the cost of health services in this country. And in the large national sense, it seems to me that the present system is based very heavily on a broadly based tax scheme, although it is not called tax. It is called premium.

Senator DURENBERGER. Well, yes, to the extent that that is built into everyone's premium. But to the extent that you have a system that is premised on the cost in Philadelphia or the cost in New Haven, particularly if you are going to an HMO or some other kind of a situation—I guess I'm correct in the statement that it's the bulk in that area then that pay for the cost of that doctor even though he may go off somewhere else.

And the concern that some people have about the all payer system in that it infranchises a system of delivering medical education and the cost thereof will give us and continue to give us the results we now see where—if I remember these figures correctly—if you go to any one of the teaching hospitals in Boston to be sick, you are paying something like 120 to 130 percent above the national average for having that particular illness treated. Whereas if you go to the Mayo Clinic, which I guess I would hold up somewhere near most of the Boston teaching hospitals, it's 80 percent of the national average.

So from the standpoint of whoever you collect that money from—whether you are collecting it from the people in Rochester or Boston or you are collecting it on a nationwide basis, such as we do in Medicare—I'm, in effect, paying out substantially more for someone to get sick in Boston, and be treated in that kind of an institution.

My additional problem, of course, is that with the cost sharing part of it, that in effect you are telling the people in Massachusetts that you are going to have to continue to pay *x* number of dollars more to educate a doctor who may leave Massachusetts. But we aren't really going to tell them that. We aren't going to let anybody in on this great thing that we are designing. Because if you told the folks in Boston that, at least the ones that voted for Ray Shamee, you are going to be out on your ear very quickly. So we can't tell them about it. So that's why we have one of these all payer systems that make it look like nobody gets hurt.

Am I wrong in my characterization?

Dr. STEMMLER. Well, I wouldn't want to get into a debate on this.

Senator DURENBERGER. No.

Dr. STEMMLER. But I would at least take a position that the system that is now operating is not terribly different from the actuarial system that operates in an insurance sense. If we had to allocate all the costs of the premium only to those people who were going to die or be in a hospital, that may be the equitable system in the way that you formulate it. It seems to me that it's complex. And, yes, the intellectual capital that is produced through this system does migrate broadly through the United States. And, in fact, in a small rural community in Utah there may very well be a physician or a group of physicians who have come from the University of Pennsylvania.

Senator DURENBERGER. Tom, do you have any reaction?

Mr. SMITH. Well, obviously, there is some distortion. The data that we showed in our comments portray 47 percent of the population supporting about 55 percent of the residents. But there's a wide skewing within that. Obviously, New York and Massachusetts are the most extreme examples of where residents are trained compared to the population present.

The point is a valid one. You have to be concerned about both skewing nationally and skewing within a local area. Some hospitals bear special burdens.

Senator DURENBERGER. Would both of you briefly address the subject that I raised with our two administration witnesses about the marketplace out there for residents and how it works; and how it seems to be changing? What is a resident worth to a hospital? And what is this issue of affordability? The fact that in some cases, the residents look like great assets and in other cases when you look at how many ancillary services they consume and how much training time has to be put in with them and the malpractice premium impact and some other things so maybe they are a liability.

Can you briefly address that? How does the marketplace work today? Then I will get a little better picture.

Dr. STEMMLER. Let me speak first then on how it looks from the point of graduation from a school of medicine when our students are competing in this world that you have defined. And, the motivation of students to pursuing their further studies in a great part deals with aspirations to get the best training program they can get. And our role in counseling students, we try to advise them where they may or may not be competitive for positions in their particular specialty of choice.

Students compete for positions; the hospitals compete to get the best students. And I think we all operate on that standard of trying to get the best for us.

There remains outside of that system—and as Dr. Graham pointed out, the capacity of that system is almost a match now for the number of American graduates. But there remain a group of institutions who for one reason or another do not seem to attract American graduates. And it seems to me as we look at where resources are deployed at least that's an area that we want to pay some attention.

But the valuable programs, as perceived by the students—the ones who are going to have hospitals, when you are inside that computer look like the most popular hospitals, it's very important that we preserve these institutions which provide the best educa-

tion so that, indeed, we continue to have the best educated physicians in the world.

Mr. SMITH. Let me just add something. As I understand it there are approximately 20 percent more openings annually than these are resident physician applicants from American schools. Obviously, as Dr. Stemmler indicated, there is wide competition for those positions. There is wide variability as to the quality of those programs. Numbers of residents that any given hospital will offer will be a function of what role those residents play in that institution. In same hospitals residents play a major role in the service delivery area, in others the service role is modest. Obviously, the better programs try to strike a good balance between service responsibilities and patient content. The residents have a very effective way of finding out what the good programs are.

The matching process, I think, works very well. There is, indeed, a strong market. The market puts the potential house officers and institutions together, I think, in effective ways. But given changes in the financing mechanism, I think the future market remains to be seen. The extent to which, in the future, it is attractive to have house staff financially will determine some settings in which these programs are made available.

Obviously, under the prior arrangement, as was commented previously, there has been no disincentive. That may or may not be the case given financing the changes.

Senator DURENBERGER. Do either of you want to add to your testimony some comments about foreign medical school graduates coming into the American market; particularly, Americans who have gone to Grenada or some other place? Australia has lots of openings, I understand. And they back in here to fill some of those residency openings.

Mr. SMITH. I might ask Dr. Knapp to comment on the AAMC's position regarding that. But I would just say that in general the orientation of an institution for an American foreign graduate is a function of what we were talking about previously, that is the attractiveness of the program; how the program is successful in competing in that marketplace.

Obviously, some institutions have used residency programs as ways to staff certain service obligations. And some of those students from those programs will fill those training positions.

I would ask Dr. Knapp to comment.

Dr. STEMMLER. Well, I would certainly make the comment that my perception of the quality of education in the schools that we are now addressing, the ones that accommodate American students in a foreign setting with a motivation to strictly earn money as a school, a proprietary school, that the quality of that education is subject to very serious criticism, as has been pointed out by the General Accounting Office audit, and others. And we are dealing with a major social problem in addressing the responsibility that we as a general public have to students who for one reason or another choose to pursue that route.

And I think that it's difficult to make a simple statement on this point. That that certainly would be an overriding statement. But my opinion is that we should preserve the graduate educational structure that operates in this country through whatever is the ap-

propriate supporting device to benefit those students who graduate through our accredited system, and to leave outside the question of Americans in foreign schools and try to deal with that issue in ways that seem to be appropriate for that issue on its own.

Senator DURENBERGER. Dr. Knapp.

Dr. KNAPP. The only thing I would say is that there are now—if I have the numbers right—roughly a two to one chance that you would be accepted in a medical school. At the same time that our numbers are leveling off, there are still those who want to get in school, and for one reason or another are not accepted. If you look at the numbers of four medical graduates right now that are residents, half of them are graduates of foreign schools who are American citizens. That's a rather difficult problem for us to deal with.

They are also concentrated in a limited number of States, if you begin to look at it carefully. I think the facts would show that while we have tried to be supportive to American citizens, we have not been big supporters of the foreign medical graduate situation currently.

One other thing. You asked before whether or not some of the hospitals were taking advantage of the fact that you can allegedly make money by adding to the number of residents that they have. We asked in the spring of this year in a survey we do annually in what specialties were physicians added and in which specialties were physicians decreased. Now I will grant you that the incentive isn't as strong as it will be, I assume, in the future, depending on how the other payers behave in the pressure on the institutions. We don't find yet that there is any reason to think that there's a pattern of increase or decrease based on the payment system.

The other thing we learned is that the decreases were where I think people would like to see them. That is, in the surgical specialties. The increase have been in family medicine, general medicine, emergency medicine and anesthesia.

Senator DURENBERGER. Do any of you know when the last medical college started up in the United States? When was the last new one? Are they coming on the market every year, a couple or three new ones?

Dr. STEMMLER. Well, I believe there are two schools presently under provisional accreditation that will emerge. I can't speak to schools that are emerging beyond that.

Dr. KENNEDY. There are none on the drawing boards that I know.

Dr. STEMMLER. We are talking about ones that are actually on line. In New York, for example, there was hope to create a school in Queens, and whether that will materialize——

Senator DURENBERGER. New York needs some more? [Laughter.]

Dr. STEMMLER. It's fascinating, Senator, but medical schools are looked upon as enormous economic resources for local communities and large employers. And there are many people who are motivated to develop medical schools on that argument alone.

Senator DURENBERGER. Is there information available about how the capital investments in medical schools are financed currently, or say within the last few years? There is some evidence in your testimony that States in some cases have undertaken—that may just have been in my State where they undertook to rebuild a less

than adequate hospital. But I assume that there is a fair amount of philanthropy out there, and a fair amount of other things th[illegible] creating these economic opportunities for some communities. Does anybody have some observations on that?

Dr. STEMMLER. I don't know if we have the information with us. Dr. Kennedy?

Dr. KENNEDY. In the huge expansion of medical schools that took place beginning with the 1963 act, a total of something on the order of 40 new medical schools were created. And the bulk of these were State-sponsored medical schools. And there was also a large expansion of first year places in existing medical schools. To a lesser extent, but nonetheless strikingly, that expansion took place in State medical schools. And I presume the capital financing for those took place both from State funds and from the Health Professions Educational Assistance Act matching grants with construction programs, and with some capital coming in from programs that existed then.

Dr. KNAPP. I think we can provide you for the record a list of the last 10 schools that were established, where they were established, and give you an idea of anything else that is on the drawing board. We will provide that in writing, if you like.

Senator DURENBERGER. I think that would be helpful.

Maybe it's only voyeurism on my part trying to find out what mix this particular industry, as such, picks. I think it relates to the product that you all are selling in some fashion. If there is a real market for your product, and it's being financed up front, then I guess everybody ought to get into this business. And it also deals with just how competitive the marketplace might be as between a variety of teaching institutions.

I have a dozen more questions. There is one question I didn't ask of the administration witnesses, and maybe you know something about it. A couple of months ago we had an HHS inspector general report about double billing under part B for some of the members of some of the faculties. Some teaching institutions were being paid for the residents under part A, and then the faculty member—I mean this was nothing specific. Maybe it was just an estimate on their part that it was going on—was then billing under part B in part for those resident services. Is that a problem that has ever been brought to your attention?

Mr. SMITH. Well, there has been much discussion of that intermediary letter 372 over the years. The extent to which there is any real abuse, I don't believe it is adequately documented. I'm sure there may be some as that study which you referred to cited. However, I think the rules seem to be reasonably explicit to prevent that from being a problem.

But Dr. Knapp may have more information.

Dr. KNAPP. The problem has been with us for at least 15 years that I know of. And in the Deficit Reduction Act, I think I'm aware that a request was put in there that the General Accounting Office take a look specifically at that.

If I understand what I think you are referring to, it's a draft inspector general's report that recommended essentially that the hospital be allowed as a passthrough cost only 1 year's training period for a resident. And that, in effect, the fee for service system along

the lines that you would probably characterize as the male model be used to support residents. We are very interested in that, as you might expect.

I think there are a number of things to look at on both sides of that question. The most difficult one, I think, has to do with the fact that unless you have pretty good leadership and control—there are some disciplines that fair very well. Those would generally be the high earning disciplines, if there weren't equity involved. And there is another set that wouldn't do very well at all. Certain aspects of pediatrics, general medicine, physical medicine, disciplines like that.

Additionally, there is an assumption in there that this would actually save money. If you look at surgery in programs currently, which are sponsored in the hospital's name, the surgeons in that hospital are not allowed to bill an assistant at surgery fee. That's something that has been a practice that you put in the statute last time around.

Now another institution without a training program, there would be a 25-percent, roughly—maybe 20-percent—increase in the fee because the surgical fee of $1,000, for example, would have $200 or $250 added onto it for assistant at surgery that is not paid in the teaching setting.

So, in effect, you have the savings on the part B side that shows up in your view as an expense on the A side. And to some degree, we are just reaching the point where we are beginning to mingle the issues of discussing professional fees with hospital services. This is a difficult area but one we are going to have to get into, perhaps reluctantly.

Senator DURENBERGER. I assume that AAMC will be part of each of these hearings. But I'm going to ask a question because I'm going to ask it in the next set of hearings.

As I look over this information about debt, I look over 4 years to get to a B.A. or a B.S., and another 4 years to get to an M.D., and then another 4 years or whatever it is up to 4 years—and I see that even halfway through that process that 32 percent have debts in excess of $30,000 and so forth. And then I see at the other end of the process the possibility that the hopes for living forever at $500,000 a year may no longer be the dream of accumulating all that debt.

I would like to ask both of you your opinions as to whether or not we are, in effect, providing too much education to all of these doctors. And that comes up in the context of the changes in the nature of the practice of medicine in this country. When it was the old fee for service individual entrepreneur system, various pressures on an individual probably required an extreme amount of specialization and technical detail. But in what seems to be a changing kind of environment in which the practice of medicine is carried out—if you have given any thought to the subject, I would appreciate your individual opinions today because I might not see you again at another hearing—whether it is possible that the way we have structured this system, we are trying to pump too much into some of these people.

Dr. STEMMLER. Well, as you know, Senator, it's very hard to define "enough" in higher education. And particularly in the pro-

fessions that bear a major responsibility that affect the public welfare. I guess one could construct a rationale that might make decisions about where the limits might be, particularly when one is looking at how funds are provided through an outside source, and place the burden on others who wish to have more education on themselves. And that concept, I'm sure, will be one that you will be dealing with as you look into this issue further.

I think the American public has set a standard for what it expects from physicians and other health professionals in the roles they play.

Senator DURENBERGER. But they have set a different standard from what the professionals have set.

Dr. STEMMLER. I think there's a natural evolution in each profession.

Senator DURENBERGER. Maybe the lawyers are setting standards.

Dr. STEMMLER. I won't touch that line.

Senator DURENBERGER. You are welcome to.

Dr. STEMMLER. But I think that in each of the health professions clearly there is an evolution where the professional is expected to acquire a broader knowledge base in order to discharge responsibilities. And that trend is continuing. And I suspect that it's continuing because at this point in time there really has not been a constraint placed, a financial constraint placed, on that trend. I have a feeling as we look ahead now those constraints will be placed, and we are going to see some adaptations on the part of the educational system to look for the introduction of efficiencies to gain instructional time and experience maybe within the constraints of produced funding.

And we are certainly prepared to look at those issues as educators. I feel very strongly that the educational community must adapt to the evolution of the service community. That we have to follow; we have to be able to prepare people to serve in whatever model is going to evolve.

Mr. SMITH. Senator, I'm not a medical educator, but I would just add an observation. Observing the scene firsthand for several years, whether or not there is enough or too much is a subject that deserves to be investigated and you deserve a good answer to that. And there are a number of organizations which I think bring credible testimony about that. I think it will be interesting to note what difference financing schemes may make in terms of the requirements for education. To be sure, under the scheme that we have followed, it has been very difficult for hospitals to resist the pressures from the medical specialty boards to extend the periods of time for training of different specialties. Clearly as long as there was an opportunity for support for those extra years of training, it was difficult to resist that pressure.

Once the tables are turned on that, and we have to put that under much more careful scrutiny, I don't know what the answer might be. To be sure, there are increasing pressures on all specialties with increasing technology to pour more and more into each student's experience.

Whether or not more or less is the appropriate answer, perhaps the better question is: What is most relevant for the use to which these individuals will spend their professional careers? That is a

worthy issue, and I think that the ABMS, the AAMC and other bodies like that——

Senator DURENBERGER. Well, I have never tried a malpractice case, but I've tried a lot of personal injury cases, and I know whatever the highest current standard is, that's the standard we try to hold every witness to and every decision to. And as you indicate, the various specialties are the ones that are responsible for adding, in effect, to the educational demand. And I would hope that—maybe I didn't phrase that question as well as I should have, but I trust that that will be a part of the study and decisionmaking process from AAMC, because I sure don't want to get into that one. I will be bound to screw it up in some way or collectively we will.

But I think if it came from the profession itself, both the educational side and the professional side—and obviously as I indicated this is a question that we will address when we get to the hearing on consumers. How much do we need of what? But it seems to me that for the practice of medicine and all the ancillary health professionals that we need to start asking some of these questions.

Dr. STEMMLER. We will see to it that our task force does it.

Senator DURENBERGER. Very good. Thank you very much for your testimony.

Dr. STEMMLER. Thank you.

Mr. SMITH. Thank you.

Senator DURENBERGER. The next panel consists of Dr. John E. Carr, acting chairman of the Department of Psychiatry and Behavioral Sciences, University of Washington Medical School on behalf of the American Psychological Association; Dr. John E. Chapman, dean, Section on Medical Schools, American Medical Association, Brentwood, TN; Dr. M. Roy Schwarz, vice president, medical education and scientific policy for the AMA; Dr. Benjamin Cohen, chief administrative officer, University of Medicine and Dentistry, New Jersey School of Osteopathic Medicine on behalf of the American Association of Colleges of Osteopathic Medicine; Dr. Louise Fitzpatrick, dean of the School of Nursing, Villanova University, Villanova, PA, on behalf of the National League for Nursing.

I thank you all for your patience today. And you have heard the ground rules so far. Try to be brief, but don't go away feeling as though you haven't shared your particular views on this subject. Your statements will be made part of the record, and you as individuals and the associations you represent here today are getting an invitation today to continue to be part of this process for the next several years to try to come up with some appropriate answers to the questions that we have phrased.

So we will begin with Dr. John Carr.

STATEMENT OF DR. JOHN E. CARR, ACTING CHAIRMAN OF THE DEPARTMENT OF PSYCHIATRY AND BEHAVIORAL SCIENCES, UNIVERSITY OF WASHINGTON MEDICAL SCHOOL, ON BEHALF OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION

Dr. CARR. Mr. Chairman, I'm Dr. John Carr, acting chairman of the Department of Psychiatry and Behavioral Sciences at the University of Washington School of Medicine. I am also president of the Association of Medical School Professors of Psychology. Its

membership is drawn from over 75 medical schools in this country, and it is an affiliate of the AAMC. I am speaking on behalf of the American Psychological Association and the Association for the Advancement of Psychology, organizations which represent more than 72,000 psychologists nationwide.

I would like to focus on two points out of our written testimony. The first is that behavioral sciences, as we have already heard, is essential to medical care and represents a major component in a comprehensive and broad based medical education program. In medical schools, psychologists play an essential role in providing the teaching for that component. These are doctoral level psychologists who are faculty members of schools of medicine.

Our second point is that while Medicare helps support medical education, Medicare has not supported or been available to support psychologist activity in medical education. Our primary concern is for the support of those faculty positions and the existing Medicare statutes which we believe to be the reason for this situation. We seek your assistance in making changes in that legislation.

To amplify on the first point, if one looks at some of the documentation that has come out of the research sector—for example, the Surgeon General's report in 1979, the Institute of Medicine report for 1981 focusing on biobehavioral research—both of those documents emphasized the need for continued focus upon the role of behavioral factors in health care, and a parallel emphasis upon our training programs to look more closely at those factors in medical education.

One of the startling findings in the Surgeon General's report, for example, was that of the 10 leading causes of death, 50 percent of the mortality associated with those causes could be attributed to behavioral factors, while only 10 percent was due to the lack of biomedical care.

We feel that health care professionals must know about the ways in which behavioral and psychological factors play an important role in the response of an individual patient to illness or to disease or even to the outcome of surgery. We feel that information is as important as it is for them to know about physiology, biochemistry, and anatomy.

Psychologists have traditionally contributed to these educational programs, and will continue to do so. We are talking about 3,500 psychologists teaching and doing research in medical schools nationwide, conducting internship programs, postdoctoral programs, involved in the training of medical students and residents as well.

Medicare payments for medical education cover both direct and indirect costs, but neither type of payment reflects the role of psychology faculty. We would suggest committee support for clarifying language to include faculty psychologists in Medicare Programs.

We very much recognize and support the committee's and Congress' efforts regarding health care costs. And we would remind the committee that the research has shown that the cost savings aspects of incorporating attention to the behavioral and psychosocial factors in health care contribute to greater economy in health care, reduced length of stay after surgery, speedy recovery, and increased adherence to the treatment regimen. These are just some of the findings of the research literature.

We seek recognition and inclusion of support for psychology faculty efforts in this endeavor. We urge the committee to take a leadership role in making changes in PPS to include psychology faculty in Medicare education payments.

Senator DURENBERGER. Thank you.

We have, in effect, by confining the PPS system only to hospitals—that's the way we reimburse psychological services. Is that right?

Dr. CARR. That's right. And under the PPS now, psychology services can only be reimbursed under part A as reimbursement to the hospital. That's been a problem for us since, like all teaching faculty in medical schools, psychologists are dependent on part of that clinical income to pay salaries.

Senator DURENBERGER. So unless you can carve a piece out of that hospital with all the other pressures on it, you don't get anything because you have been barred from part B.

Dr. CARR. Yes. Someone earlier mentioned two factors. Principal and product. Now we think the records show fairly clearly we have a good product to sell. And in terms of the principal, we have been a part of the medical education scene for a long time. We would like to continue in that effort.

Senator DURENBERGER. Thank you.

[The prepared written statement of Dr. Carr follows:]

American
Psychological
Association

TESTIMONY OF

John E. Carr, Ph.D.

Acting Chair

of the Department of Psychiatry

and Behavioral Sciences

University of Washington

School of Medicine

on behalf of

THE AMERICAN PSYCHOLOGICAL ASSOCIATION

and

THE ASSOCIATION FOR THE ADVANCEMENT OF PSYCHOLOGY

SENATE FINANCE COMMITTEE

Subcommittee on Health

on the subject of

MEDICARE PAYMENTS FOR MEDICAL EDUCATION

October 1, 1984

Sen. David Durenberger, Chairman

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Washington, D.C. 20036
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Mr. Chairman and Members of the Committee, I am Dr. John E. Carr, a clinical psychologist, and Acting Chair of the Department of Psychiatry and Behavioral Sciences at the University of Washington School of Medicine. I am also President of the Association of Medical School Professors of Psychology. Its membership is drawn from over 75 medical schools in the country and it is an affiliate of the Association of American Medical Colleges. I am speaking on behalf of the American Psychological Association and the Association for the Advancement of Psychology, organizations representing 72,000 psychologists nationwide.

I am pleased to be here to comment on the way Medicare pays for medical education. I would also like to discuss a unique aspect of the Medicare system as it affects medical school faculty members who are psychologists.

Presently, Medicare pays for medical education in two specific ways: a pass-through for direct costs such as salaries, stipends and space; and an indirect cost adjustment based on the ratio of hospital interns and residents to the number of hospital beds. Clearly, there is recognition of the fact that the operation and finances of a hospital are significantly affected by its teaching programs.

We will focus on two issues in our testimony. First, medical education is becoming broader as technology and our population changes. Teaching hospitals, especially in terms of their attention to the behavioral and psychological aspects of illness, reflect and reinforce these changes. Our second issue is that nonphysicians are involved in medical education and that this involvement is affected by Medicare. The medical education payments

clearly influence the ability of teaching hospitals to deliver a broad range of health services. They help pay the extra costs due to greater severity of illness and necessary special staffing patterns that occur in teaching hospitals. What these payments do not reflect, and what the Medicare program itself does not recognize, is the role of nonphysician clinical faculty in this training process.

We believe that neither the direct medical education payment, now a pass-through in the Medicare Prospective Payment System (PPS), nor indirect teaching cost adjustments to the PPS rate, should be changed without serious consideration of how these changes might affect services offered by teaching hospitals, and the scope of medical education in this country. Proposals to support the direct medical education payment through a separate budget category for health professions training puts this important educational function at risk, and violates the principle that medical education and clinical care should be integrated. Even greater uncertainty, however, is attached to the potential impact of the indirect cost adjustment as administrators and health care professionals attempt to anticipate the complex effects of a DRG system that provides incentives for surgical and procedure based services rather than diagnostic judgement and non-surgical care.

We should clarify for the Committee that the over 900 psychology interns currently in medical schools and affiliated teaching hospitals receive no support under either the direct or the indirect teaching cost payment provisions of Medicare. Nor are psychology interns included in the intern-to-bed ratio for the purposes of the indirect payment calculation. If the intern-to-bed ratio is to be used as a proxy for the illness severity found in teaching hospitals, and

illness severity as well as training needs are a special feature of teaching hospitals, then all post-doctoral clinical interns should be included. We suggest that any changes in the payment structure incorporate attention to this issue.

Further, if Medicare continues its support for medical education, some provision clearly needs to be made for nonphysician medical school faculty and their clinical services to guard against the elimination of their valuable role value in medical school curriculum.

There is considerable concern regarding how hospitals will respond to the fiscal pressures generated by the Medicare prospective payment system. One possible outcome that is being borne out by preliminary data is that hospitals will discharge patients sooner. Ancillary services will be reduced to cut costs. Hospitals will de-emphasize treating certain categories of patients, or prefer to treat those whose diagnosis renders them eligible for the highest possible reimbursement rate. "Outlier" cases, those that cost more or stay longer than the Diagnosis Related Group (DRG) algorithm allows, will cause the hospital to lose money. "Inliers," those that cost or stay within the limits assigned to the DRGs, will enable the hospital to make money. The balance between these two categories of patients is what a hospital will closely monitor, or should, to enable it to survive fiscally.

The question for teaching hospitals is whether the higher rate of outlier cases will be sufficiently compensated for by the profit performance of the inliers and the direct and indirect cost adjustments. The available evidence, though sparse, raises legitimate concerns that these costs may not be covered. A recent study at Stanford University Medical School reported that, after adjustment

for diagnosis, costs were still eleven percent higher in the faculty service than in the community service of the hospital. However, the mortality rate was significantly lower, especially for patients in the high-death-risk category. This is surely an appropriate trade-off.

In a teaching hospital, balanced and comprehensive services must be maintained to accommodate the medical curricula. Achieving the balance necessary from a fiscal point of view is thus more difficult. There is concern that medical/surgical procedures will be increased at the expense of other services and lead to a forced redistribution of available services. Furthermore, many teaching hospitals have a closed staff system and rely heavily on non-physician specialists. A 1983 study from the Institute of Medicine (Personnel Needs and Training for Biomedical and Behavioral Research) states that Ph.D.s accounted for more than 15 percent of clinical department faculty in medical schools in 1982. The reasons these unique staffing patterns are relevant to this hearing are the following:

one: the use of non-physicians permit lower cost augmentation of the available physician pool.

two: there is greater emphasis on psychological and behavioral services in addition to biomedical in a teaching hospital; and

three: multidisciplinary team approaches that incorporate both of the features have become standard treatment patterns in many teaching hospitals.

Teaching hospitals have a strong emphasis on psychological as well as biomedical treatment procedures, and recognize the value of psychological services in conjunction with biomedical care. There is a considerable body of research literature documenting that when psychological aspects of care are

incorporated, length of stay is decreased, recovery is hastened, and patient adherence to treatment regimens is promoted. It is notable that much of the research that has been done in this area took place in teaching hospital settings.

The teaching focus attempts to accommodate a complete approach to health care; its purpose is to educate physicians and other health care professionals in the broadest possible sense. A report just released by the Association of American Medical Colleges stresses that medical education programs need to change so that physicians are better equipped in the attitudes and skills of a "caring profession." The use of multidisplinary teams and psychiatric/behavioral sciences linkages to medical/surgical units are major features of most teaching hospitals and play an essential role in the development of these professional attributes.

The broad relationship between health and behavior has received increased attention in recent years, especially since the 1979 Surgeon General's report "Healthy People." The report stated that seven of the ten leading causes of death in the U.S., are in large part behaviorally determined. As a result, most medical schools have devoted serious attention to health and behavior in their curricular design. At the University of Washington, for example, two years of pre-clinical courses in behavioral sciences are required of all students. The National Board of Medical Examiners examination, which all physicians must take in order to practice, includes a section on behavioral sciences. Psychologists who are faculty in medical schools play a key role in this aspect of medical school training. The Association of Medical School Professors of Psychology estimates that there are about 3,300 psychologists on the faculties of most of the nations 126 medical schools.

There is another aspect of the Medicare program that directly affects the ability of nonphysicians to participate in medical education. A common arrangement with medical school faculty members is a provision in their

contracts to generate clinical fees. In the past, this was the primary way all medical school faculty were paid, but in recent years medical schools have received funding from other resources, including state and federal monies. The prospect for nonphysician clinical faculties to maintain revenues from fee income is problematic due to the unintended consequences of the PPS system.

The PPS system requires that all services provided for hospital patients must be billed for by the hospital. Separate billing is no longer allowed for any hospital services, except those personally delivered by physicians. The intent of the prospective reimbursement legislation was, we understand, to give hospital administrators more authority over services for which the hospital will be held fiscally responsible. Before prospective payment, psychologists were allowed to bill through a physician under Part B of Medicare (medical and related services) for services delivered to hospital patients. This is no longer the case. Now psychologists are dependent on the hospital administrator to determine whether and to what extent their services will be recognized under PPS. It is under this mechanism that psychologists who are medical school faculty find themselves in a unique position. In effect, PPS jeopardizes the ability of medical colleges to continue funding psychologists' faculty salaries, when such salaries are dependent upon income from clinical fees. The Medicare payment system effectively shifts the fiscal authority for psychologist faculty members from the dean of the medical school to hospital administrators.

Full-time regular medical school faculty members, be they physicians or psychologists, are not employees of the hospital but are employees of the University. Our point is that psychology faculty paid by the University and

teaching under its responsibility, is suddenly susceptible to control by the hospital administrator under PPS.

HCFA insists that the costs of a medical education program operated by "another institution" be "borne by that institution and not by the hospital." The PPS makes it necessary that the clinical services of nonphysician medical school faculty be paid by the hospital. To that extent, the hospital is required to pay for, and absorb, the costs of medical education. Given the cost constraints imposed upon hospitals by the new Medicare plan, it is extremely difficult, if not impossible, for hospitals to assume added faculty costs. It is highly likely that positions or programs depending on clinical fees from psychologists are in jeopardy.

The Medicare prospective payment plan thus puts at risk the teaching of behavioral sciences in schools of medicine, much of which is conducted by psychologists on the faculties of schools of medicine. It also puts at risk continuation of nationally recognized clinical services, many of which use the latest concepts in behavioral medicine, and many of which are administered, developed, or staffed by faculty psychologists.

It is important to emphasize that this is an issue of concern for medical schools in general. It affects the quality of medical education, the quality of medical care, access to medical care, and goes beyond any specific guild concern psychologists may have.

Let me be more specific with my own experience. The University of Washington Medical School is a regional medical center and serves the four states of Washington, Idaho, Montana, and Alaska. There are 75 psychologists in the medical school. The greatest number, 28, is in the department of psychiatry but psychologists also practice in the departments of neurosurgery, pediatrics and family medicine, and rehabilitation medicine. The

psychologists are all academic faculty of the University of Washington; at least half of them provide direct clinical services in conjunction with or in addition to their teaching and research duties. They all have staff membership with the five affiliated teaching hospitals.

Psychologist faculty's ability to generate the necessary clinical fees for position support through a partnership services plan has been parallel to that of physician faculty members of the partnership. This has now changed. I believe that the impact of the PPS on psychologist faculty will negatively affect the following training and service capacity of the following programs at the University of Washington: 1) the internationally known University of Washington pain service at University Hospital, 2) in-patient behavioral/cognitive treatment programs for affective disorders at University Hospital and Harborview Medical Center, 3) geriatric services at University Hospital, 4) behavioral medicine consultation services at University Hospital, 5) neuropsychology laboratories and psychology diagnostic services at University Hospital and Harborview Medical Center, 6) the rehabilitation medicine operant pain program at University Hospital, and many other services.

These programs are among the most effective and cost-effective treatment modalities available for certain medical, psychiatric, and behavioral disorders. Medicare thus has the potential to force the department to eliminate the best care from public use, to curtail its availability for training purposes, and to deny care to a most needy population, namely the aging and less financial able.

Our attempts to resolve this issue have resulted in a great deal of frustration. The Health Care Financing Administration in its regulations on prospective payment did provide for issuing certain waivers. The procedures outlined for these waivers, however, were extraordinarily difficult to

satisfy. First of all, teaching hospitals did not anticipate the need to include the services of non-physician medical school faculty members in the base rate they established prior to implementation of PPS. Furthermore, to obtain a waiver, the hospital had to show that the direct billing for a particular service was so extensive that to change it would "threaten the stability of patient care." Although psychologists provide distinct services, they could not stand independently and satisfy the regulatory requirements for a waiver.

The only successful waiver for a whole category of providers that we are aware of, in this regard, is that authorized by Congress earlier this year for Certified Registered Nurse Anesthetists. One of the primary reasons why this was granted was that these services could be performed by physicians but were also provided by non-physician personnel. In those cases, Congress agreed that the system provided an unfortunate incentive for hospitals to replace services provided by non-physician professionals with those provided by physicians on a more costly, but separately billable, basis. We could, of course, accurately make the same claim for psychologists' services. However, the Health Care Financing Administration has made it quite clear that they are in no mood to make any other exceptions to the rebundling provisions of the prospective payment law.

The greater implication of this Medicare's payment system is broader than the economic justification or arguments for the substitutability of psychology services with those of physicians. In this particular case, we are talking about a fundamental aspect of medical education--behavioral sciences--and the extent to which health professionals who play a key role in providing teaching and services have their stability jeopardized by the requirements of PPS. Furthermore, to recommend that these faculty salaries be passed on to

university hospitals is unrealistic and fails to take into account the fact that these individuals are academic faculty of a university medical school, not staff employees of any hospital.

Both Congress and The Health Care Financing Administration have recognized that PPS was not perfect as it was adopted. Many changes were expected to refine the DRGs themselves, and to assure that quality-of-care concerns were not sacrificed for fiscal expediency. Yet no clear direction has emerged on how or by whom these changes will be made. Indeed, the priority continues to be how to decrease the federal government's share of payments even further. HCFA is overburdened with the initial implementation of the system and a myriad of special reports that were requested in the original legislation. The Professional Review Organizations, intended to be the overseers of quality couched in auditor's garb, have yet to be operational in every state. HCFA clearly sees its responsibility primarily in fiscal terms. General opinion has it that the Prospective Payment Assessment Commission recommendations, especially concerning rate adjustments, will surely lag behind market reality by as much as three years. Last spring, when we spoke to members of that Commission on this very problem, we were told that the Commission was nowhere near being able to address the issue of medical education, much less the impact of PPS on psychologist faculty.

We commend the necessary actions by this Committee and the Congress to control health care costs in this country. We urge this Committee to take a leadership role to make changes in the PPS to more accurately reflect the fact that medical education has changed dramatically since the original implementation of Medicare. Psychology would like to contribute its expertise on this and related matters in whatever way possible.

Thank you.

STATEMENT OF DR. JOHN E. CHAPMAN, DEAN, SECTION ON MEDICAL SCHOOLS, AMERICAN MEDICAL ASSOCIATION, BRENTWOOD, TN

Senator DURENBERGER. Dr. Chapman.

Dr. CHAPMAN. Mr. Chairman, my name is John Chapman. I'm a physician and dean of Vanderbilt School of Medicine and a member of the governing council of the American Medical Association's Section on Medical Schools. Accompanying me are Dr. Roy Schwarz, who is vice president for medical education and science policy at the AMA; as well as Harry Peterson, who is director of the AMA's Division of Legislative Activities.

The AMA is pleased to have the opportunity to testify before this committee concerning the financing of medical education costs under the Medicare Program.

The AMA has a long history of active involvement in and support for quality medical education. We believe that good medical care for the American public is dependent upon the existence of a large cadre of well trained physicians and other health care professionals. This belief is at the heart of the AMA's purpose and formed the basis for its establishment in 1847.

The education of physicians is long and arduous, requiring years of classroom work. The first 2 years of medical education in medical school focus upon the basic sciences in classroom and in laboratory experiences. In the last 2 years, as students study the clinical sciences, there is an increase in the integration of the student into the patient care team at the bedside, on the wards, and in the clinics.

After graduation from medical school, intensive participation in patient care begins. Graduate medical education, commonly referred to as "residency training," places a physician in training in a learning and service environment in which he or she cares for patients under the supervision of licensed physician teachers.

The resident participates in the diagnosis and in the management of large numbers of patients who present a wide spectrum of disease states, and acquires the requisite knowledge and skills of his or her chosen specialty. The residency is designed to offer the resident increasing levels of responsibilities and to prepare him or her for the independent practice of medicine.

The AMA believes that the U.S. medical education system, both undergraduate and graduate, is second to none, and is an essential component for assuring high-quality health care for the American people.

We strongly support the current system for funding graduate medical education through third-party payors, including Medicare. A key benefit of the existing system of funding for graduate medical education is the stable financial environment which it has fostered. This predictable financial environment in which teaching hospitals are assured that reasonable, direct and indirect medical education costs will be reimbursed has been a major reason for the number and the quality of teaching programs available. Without such support, hospitals would be forced to choose between two undesirable alternatives—eliminate the teaching programs or to face revenue shortfalls.

At the same time, teaching hospitals and teaching programs provide a number of significant benefits for the general public. Certainly all of society benefits from having a large cadre of highly trained physicians in the medical specialties. In addition, teaching hospitals generally have more special care units, such as units to treat cancer or heart attacks than do nonteaching hospitals.

As a result, teaching hospitals often serve as the medical referral center. Finally, in teaching hospitals residents, under the supervision of attending physicians, provide quality patient care. In the absence of residents, hospitals would be forced to hire practicing physicians and thereby could incur increased costs.

The present financing system recognizes that legitimate reasons may exist for higher patient cost in teaching hospitals. Teaching hospitals generally treat more complex and more severe cases, provide more technologically intensive care, and provide more uncompensated or insufficiently compensated care to low income and indigent patients.

In addition, because teaching hospitals usually contain many special care units, overall occupancy may be lowered.

In conclusion, Mr. Chairman, we believe that the U.S. medical education system, both graduate and undergraduate, is the benchmark against which other medical education systems are judged. Preeminence in graduate medical education has been achieved by virtue of society's commitment to good medical care, the dedication of medical schools and teaching hospitals to high caliber education, and the existence of a stable funding mechanism.

We are extremely concerned over proposals such as those made by the Department of Health and Human Services Advisory Council on Social Security to restructure the financing of graduate medical education without a clear view as to appropriate replacement. Precipitous action could severely impact on the quality of medical education and ultimately on the quality of medical care in the United States by undermining the Nation's ability to train qualified physicians in sufficient numbers to meet health needs.

Thus, we urge Congress to ensure that the Medicare Program continues its long-standing support of graduate medical education and continue to pay its fair share of the cost of a system that benefits Medicare beneficiaries and the Nation as a whole.

I stand ready to respond to inquiries.

Senator DURENBERGER. Thank you, Dr. Chapman, very much.

[The prepared written statement of Dr. Chapman follows:]

STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

to the

Subcommittee on Health
Committee on Finance
United States Senate

Presented by

John E. Chapman, M.D.

RE: Funding for Medical Education Programs under Medicare

October 1, 1984

Mr. Chairman and Members of the Committee:

My name is John E. Chapman, M.D., and I am Dean of the Vanderbilt School of Medicine and a member of the Governing Council of the American Medical Association's Section on Medical Schools. Accompanying me are M. Roy Schwarz, M.D., Vice President for Medical Education and Science Policy of the AMA and Harry Peterson, Director of the AMA's Division of Legislative Activities. The AMA is pleased to have the opportunity to testify before this Committee concerning the financing of medical education costs under the Medicare program.

The AMA has a long history of active involvement in and support for quality medical education. The AMA believes that good medical care for the American public is dependent upon the existence of a large cadre of

well trained physicians and other health care professionals. This belief is at the heart of the AHA's purposes and formed the basis for the establishment of the Association in 1847.

The education of physicians is a long and arduous process requiring years of classroom work with increasing exposure of students and physicians-in-training to the practical aspects of patient care. The first two years of education in medical school focus generally on the basic medical sciences in classroom and laboratory experiences. In the last two years, as students study clinical sciences, there is increasing integration of the student into the patient care team at the bedside. After graduation from medical school, intensive participation in patient care begins in the form of graduate medical education. Graduate medical education, commonly referred to as residency training, places the physician-in-training in a learning and service environment in which he or she cares for patients under the supervision of licensed physicians-teachers. The resident participates in the diagnosis and management of large numbers of patients who present a wide spectrum of disease states and acquires the requisite knowledge and skills of his or her chosen specialty. The residency is designed to offer the resident increasing levels of responsibility and to prepare him or her for the independent practice of medicine.

It is through the provision of patient care in a teaching environment that a physician learns the practice of clinical medicine. It is difficult if not impossible to separate the learning and service components of medical education. "Hands on" experience is absolutely necessary.

The AHA has a long standing and direct involvement in assuring the quality of graduate medical education in the United States. The AHA actively participates in the voluntary accrediting of medical schools through the Liaison Committee on Medical Education, of residency programs through the Accreditation Council for Graduate Medical Education, and of continuing medical education programs through the Accreditation Council for Continuing Medical Education. In addition, we have on numerous occasions supported efforts to provide federal financial assistance for undergraduate medical education programs. We have also strongly and consistently supported federal financial aid for medical students to insure that qualified individuals have an opportunity to pursue a medical career where there are insufficient family resources.

The current system of medical education, both undergraduate and graduate, in the United States is second to none and is an essential component for assuring high quality health care for the American people. We strongly believe that in order to maintain this position a stable environment must exist for the financing of medical education at all levels.

The AHA strongly supports the current system whereby Medicare and other payor entities share in the cost of medical education. Medicare beneficiaries as well as persons covered by other health plans share in the benefits of our medical education system by receiving health care services from well-trained and well-qualified medical professionals.

We are concerned that withdrawl of Medicare funding for direct and indirect costs of medical education, as has been suggested by some, would severely impact on the quality of medical education and ultimately the quality of medical care in this country.

We commend this Committee for beginning an inquiry into the financing of medical education under the Medicare program. The system of financing medical education is complex. Changes must be carefully evaluated and considered since an ill-advised change could threaten the nation's ability to train qualified physicians in sufficient numbers to meet the health needs of our nation.

Mr. Chairman, I will now describe the existing financing system and explain why we believe it has served our nation well.

Current Financing of Graduate Medical Education Costs by Medicare

Existing law provides that a hospital will be reimbursed outside the prospective payment system for its direct and indirect medical education costs.

Direct Costs

"Direct costs" are expenses directly associated with an approved medical education program operated by a hospital. These costs include the salaries and fringe benefits of residents and the portion of the salaries of teaching physicians attributable to educational activities. Under the Social Security Amendments of 1983, such expenses continue to be paid by Medicare on a reasonable cost basis.

According to the Council on Teaching Hospitals' Survey of Housestaff Stipends, Benefits, and Funding, teaching hospitals on an average spent over $3 million on salaries and fringe benefits for residents during the 1982-83 academic year. This amount represented an increase of 3.4% over the amount spent in 1981-82. Teaching hospitals are extremely dependent on patient care revenues for the support of housestaff salaries and fringe benefits and generally have nowhere else to turn for resources to

cover this vital function. An average of over 83% of the funding for these expenses in teaching hospitals, exclusive of Veterans' Administration hospitals, was obtained from "patient revenues." The term "patient revenues" includes payments from Medicare, Medicaid, Blue Cross, commercial insurance carriers, and direct patient payments. Other sources of funding for housestaff expenses include state and local governments (8%), the Veterans' Administration (1.5%), universities (2%) and other sources (5.5%), including federal agencies, private grants and endowments.

Indirect Costs

"Indirect teaching costs" are expenses of a teaching hospital not directly attributable to the hospital's medical education activities. These costs include the additional expenses involved in treating more seriously ill patients and the added costs associated with the teaching of residents. The Medicare program also pays hospitals' indirect costs of medical education. A hospital's indirect medical education payment is calculated by multiplying its total DRG revenue, an education adjustment factor that represents the effect of teaching activity on the hospitals operating costs, and a factor representing each 0.1 increase in the hospital's ratio of full-time equivalent residents to beds.

In reporting the Social Security Amendments of 1983, the House Ways and Means Committee acknowledged that an additional payment to teaching hospitals for indirect education expenses is appropriate

> . . . in the light of serious doubts (explicitly acknowledged by the Secretary in his recent report to the Congress on prospective payment) about the ability of the DRG case classification system to account fully for factors such as severity of illness of patients requiring the specialized services and treatment programs provided by teaching institutions and the additional costs associated with the teaching of residents.

The latter costs are understood to include the additional tests and procedures ordered by residents as well as the extra demands placed on other staff as they participate in the education process. Your Committee emphasizes its view that these indirect teaching expenses are not to be subjected to the same standards of "efficiency" implied under the DRG prospective system, but rather that they are legitimate expenses involved in the post graduate medical education of physicians which the Medicare program has historically recognized as worthy of support under the reimbursement system.

Benefits of the Existing Financing System

The AHA strongly supports the current system for financing graduate medical education through third party payors including Medicare. A key benefit of the existing system of funding graduate medical education is the stable financial environment it has fostered. This predictable financial environment, in which teaching hospitals are assured that reasonable direct and indirect medical education costs will be reimbursed, has been a major reason for the number and quality of teaching programs available. We are concerned over proposals to restructure the financing of graduate medical education because no stable alternative funding sources have been identified. Without predictable financial support, teaching hospitals would be forced to choose between two undesirable alternatives: eliminate essential teaching programs or face large revenue shortfalls.

At the same time, teaching hospitals and teaching programs provide a number of significant benefits to the general public. Certainly, all of society benefits from having an adequate supply of highly trained physicians in all medical specialties. In addition, teaching hospitals generally have more special care units such as units to treat cancer or heart attack than do non-teaching hospitals. As a result, teaching hospitals often serve as the medical referral center for an area offering

tertiary care unavailable elsewhere in a community. Finally, in teaching hospitals residents under the supervision of attending physicians provide quality patient care. In the absence of residents, hospitals would be forced to hire practicing physicians and thereby could incur increased costs.

The present system recognizes that legitimate reasons exist for higher patient costs at teaching hospitals. Teaching hospitals generally treat more complex and severe cases, provide more technologically intensive care, and provide more uncompensated or insufficiently compensated care to low-income and indigent patients. In addition, because teaching hospitals usually contain many special care units, overall occupancy rates may be lower than those of non-teaching hospitals where beds may be available for general admission.

Conclusion

The U.S. medical education system, both graduate and undergraduate, is the benchmark against which other medical education systems in the world are judged. Preeminence in graduate medical education has been achieved by virtue of society's commitment to good medical care, the dedication of medical schools and teaching hospitals to high-caliber education, and the existence of a stable funding mechanism.

We are extremely concerned over proposals such as those made by the Department of Health and Human Services' Advisory Council on Social Security to restructure the financing of graduate medical education without a clear view as to how graduate medical education will be financed. Precipitous action could undermine not only our graduate medical education system, but the quality of our health care system as a

whole. Thus we urge Congress to ensure that the Medicare program continues its long-standing support of graduate medical education and continues to pay its fair share of the costs of a system that benefits Medicare beneficiaries and the nation as a whole.

Mr. Chairman, thank you for providing us with this opportunity to testify, I will be happy to answer any questions Members of the Committee may have.

STATEMENT OF DR. BENJAMIN COHEN, CHIEF ADMINISTRATIVE OFFICER, UNIVERSITY OF MEDICINE AND DENTISTRY, NEW JERSEY SCHOOL OF OSTEOPATHIC MEDICINE, ON BEHALF OF THE AMERICAN ASSOCIATION OF COLLEGES OF OSTEOPATHIC MEDICINE, WASHINGTON, DC

Senator DURENBERGER. Dr. Cohen.

Dr. COHEN. Thank you, Mr. Chairman.

I'm the dean of the university of medicine and dentistry, New Jersey School of Osteopathic Medicine, and I'm representing the American Association of Colleges of Osteopathic Medicine. The osteopathic profession is a profession of primary care, of health promotion, and of disease prevention. Eighty percent of all of the osteopathic physicians are engaged in primary care, with 50 percent practicing in areas populated with 50,000 persons or less.

The model that we utilize for graduate education is different in both scope and environment than the traditional medical graduate system. Our graduates serve a rotating internship during the first postgraduate year. That internship is geared toward primary care, and primary care issues. The internship takes place in small- to medium-sized community hospitals. Many of the faculty members are private practitioners who have volunteered their time. The great difference between the osteopathic and allopathic professions' graduate program, lies in the fact that most institutions where our graduate medical education takes place is in the private sector, the smaller community medical hospitals.

We are pleased that Congress has had the wisdom to finance medical education both for the direct cost for Medicare reimbursement and indirect adjustments as the development of a PPS occurs. We certainly support the necessity for the survival of quality medical education and for the continuation of such reimbursement. The current reimbursement plan permits the osteopathic profession to continue its graduate medical education outside of large tertiary centers.

However, we think that there is a great vulnerability to that continuation. Because of the cost containment environment, any retrenchment in costs related to medical education moneys allotted to small- and moderate-sized community hospitals will force hospital boards and their administrations to consider the fiscal viability of the institution. This fiscal reconsideration could be done at the expense of medical education. The osteopathic medical profession is

concerned because our primary care programs are conducted in community hospitals. We note that most hospitals have short experience with the PPS system, and that the jury is still out. We do need another year or two before we can address that issue.

The exact nature of indirect costs for medical education is still perplexing. It lacks clear definition and experience, and awaits a more concise delineation of its possible effects and implications.

We urge the continuum of medical education support through the Medicare system. We urge that no programmatic changes occur until the facts are in. I regard it as analogous to a microscope which has on its stage, medical education. There are two knobs of adjustments on microscopes, the gross and the fine adjustment. A great programmatic change prematurely placed upon the microscopic stage might put our whole system grossly out of kilter, disregarding the fine focus of current educational workings.

The long-range facts must be considered. We urge Congress to look at the future so we can address some of the impending issues of medical education. We must realize as we approach the end of the decade, that there are predictions of a surplus of 70,000 physicans. Clearly, the need for more cost-conscious primary physicians is evident when we look at that surplus. Hospitals of the future will be leaner. They will care for the gravely ill, operate on the most major cases, and accept only those patients who are unable to ambulate. The bulk of medical practice in the future probably will switch from in-hospital to ambulatory health care.

We hope that these centers will be sites for a prototype of training for our physicians of tomorrow. Medical education in the future will look toward the reimbursement system that takes into account the ambulatory services of this country.

Last, if I may say, I think the strength of this country not only exists with the individual institutions and its industries which are able to look at options, but thanks to individuals like you, Mr. Chairman, the strength of our Nation rests on the tradition of hearing the public and registering the pulse beat of this country.

I hope that the testimony today will make the Senators realize that all of us are asking essentially for a continuation of the system until we can come up with the adequate facts, consider implications of change, and address the issues with wisdom and forethought.

Thank you.

Senator DURENBERGER. Very good. Thank you very much, Dr. Cohen.

[The prepared written statement of Dr. Cohen follows:]

AACOM

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Office of Governmental Affairs

TESTIMONY ON

MEDICAL EDUCATION FUNDING BY THE MEDICARE PROGRAM

Good afternoon, Mr. Chairman and members of the Subcommittee. My name is Dr. Benjamin Cohen; I am an osteopathic physician and serve as Dean of the University of Medicine and Dentistry of New Jersey/College of Osteopathic Medicine. My statement to you today will reflect the perspective of the American Association of Colleges of Osteopathic Medicine and its member colleges. We are pleased to have this opportunity to provide the Subcommittee with our view of the current medical education financing mechanism under medicare.

As you may know, the osteopathic profession practices medicine based on significant components of primary care, health promotion, and disease prevention. That holistic approach is reflected in the kind of health care services provided by our physicians. Over 80 percent of the osteopathic medical profession are engaged in the delivery of primary care services. More than half of the profession provide health care services to communities of less than 50,000 persons. The osteopathic medical education process is an integral and vital part of our success in delivering those valuable health care services.

Both the model and the environment of osteopathic graduate medical education vary significantly from those of allopathic medical education. Upon award of the D.O. degree, osteopathic physicians must complete a one year, rotating internship prior to any specialized residency training. That internship experience most often occurs in small to moderate size community hospitals. Some of the smaller facilities join to form consortiums in order to provide their interns with exposure to the full range of medical services. Finally, a significant portion of our teaching physicians are private practitioners who volunteer their time for teaching activities.

While osteopathic medical education makes an important contribution to this profession's ability to respond to national health care needs, funding for that education has grown increasingly precarious. Our heavy reliance on graduate medical education within the private sector of small, community hospitals means that more traditional sources of medical education support such as faculty funds, endowment funds, and federal research dollars frequently are not available to this profession. The historical recognition of medical education costs under medicare has allowed our training programs to continue producing the kind of practitioner most needed by this nation.

We were pleased when Congress took special care to continue recognition of medical education expenses via medicare's pass through of direct medical education costs and retention of an indirect medical education adjustment during its development of the prospective payment system. As the full Senate Committee on Finance articulated upon reporting out the PPS measure, medical education costs "are legitimate expenses involved in the postgraduate medical

education of physicians which the medicare program has historically recognized as worthy of support under the reimbursement system."

Continuation of that federal reimbursement policy by Congress is invaluable. Medicare reimbursement for the costs of graduate medical education has contributed manifoldly towards the on-going development of quality, hospital-trained physicians for this nation. For the osteopathic profession, that contribution has been particularly valuable. It has had a positive impact on our ability to operate graduate medical education programs outside of the large, tertiary care centers. It also has enabled us to continue to produce a population of physicians which provide badly needed health care services, mostly in the area of primary care.

However, the future of medical education is becoming increasingly vulnerable. As hospitals seek ways to hold down costs and operate within the constrairts of PPS, increased scrutiny may be turned towards the fiscal viability of maintaining hospital-based graduate medical education programs. Indeed, a growing reluctance on the part of some for-profit hospitals to maintain medical education programs has already been evidenced. We believe maintenance of medicare reimbursement for medical education costs is essential.

More specifically, we support the continuation of the current medical education financing mechanism under medicare during this period of time in which the prospective payment system fully evolves. We do so for several reasons. In the short-run, inclusion of osteopathic hospitals and their graduate medical education programs under the new system has been brief. Many of our hospitals

have participated for only a few months and any impact specific to medical education is difficult, if not impossible, to discern at this point. In the long-run, it will be several years until the current medicare reimbursement system, as fully envisioned by Congress, is completely in place. On both measures, Mr. Chairman, the data regarding the impact of PPS on medical education simply is not yet in.

There exists another, perhaps more significant, reason for refraining from making any immediate judgements or decisions regarding the financing of medical education under medicare. To date, there is little information available regarding the exact nature of indirect medical costs, teaching physicians, and teaching hospitals. Collaborative efforts among those individuals most directly involved in medical education, Congress, and the Administration could contribute significantly to that body of knowledge. For that reason, this hearing is a useful forum and we are grateful to the Subcommittee for recognizing its importance.

As you undoubtedly are aware, several other efforts have been initiated to address this need. The Health Care Financing Administration has been working for several years to issue regulations regarding the reimbursement of physicians in teaching hospitals. Difficulty in defining medical education items and clearly delineating those from health care delivery items has contributed to the delay in promulgating the regulations. In addition, the Office of the Secretary, Department of Health and Human Services has begun a four year study of the financing of graduate medical education. Two years of that study remain.

Clearly, much of the information needed to review the impact of current medical education reimbursement policy as well as the level of that reimbursement currently is being accrued. We believe that any programmatic change in medicare reimbursement for medical education should wait until all of the facts are in. Only then can such policy be reviewed and shaped in a comprehensive and deliberate manner.

We have a more immediate concern as well. We caution against reducing current reimbursement levels provided through the indirect medical education adjustment. For the osteopathic medical education community, in which medical training occurs through a network of small to moderate community hospitals, any precipitous retrenchment in that adjustment would jeopardize seriously our ability to continue producing the very kind of practitioner most needed.

On a more long-term basis, we believe that federal policy regarding reimbursement for medical education costs under medicare will affect the nature of health care delivery. It is clear that the federal government has the potential to exert a powerful influence on the development and utilization of specific, high-priority products through such mechanisms as federal reimbursement policy. The continued need for primary care providers, in a cost-conscious environment, is evident. We believe the federal government's impact on graduate medical education, through reimbursement policy, could contribute towards responding to that need.

Further, it is apparent to everyone that the traditional scenario for hospital care is undergoing rapid change. We are viewing a future hospital which is slimmer and leaner and caring for a sicker patient. Concurrent to that vision

is one in which many of the services traditionally provided in a hospital will be provided in ambulatory care centers. Graduate medical education can, and we believe should, play a vital role in preparing, future physicians to participate in that new prototype of care. Again, we believe the federal government's policy towards graduate medical education reimbursement could affect that role in a very positive way.

Continuation of the current reimbursement policy ensures some level of positive federal impact on training programs which respond to current national health care priorities. In that limited way, medical education programs, such as those conducted within the osteopathic profession, which are not frequently eligible for other sources of funding yet provide the nation with a cadre of physicians whose primary focus is the delivery of primary care services, are encouraged. We urge the Subcommittee to regard the current funding mechanism and any future policy change in light of their impact on such graduate medical education programs, with a view towards strengthening their potential to respond to national health care needs.

Our conclusions for your consideration as you study the current medical education reimbursement system under medicare are two-fold. First, we believe that the current funding mechanism should remain in place until all of the information needed to make policy recommendations is available. That recommendation is inclusive of both general reimbursement policy and the specific level of reimbursement provided through the indirect medical education adjustment.

Second, we believe strongly that, through such reimbursement policy, the federal government can, and should, encourage the viability of systems in which high-priority resources are developed. We believe particular attention should be focused on teaching programs, such as the ones within the osteopathic medical education community, which rely heavily on a network of small, community hospitals. The federal government, through such a focus, can help in providing for the continuation of efforts to produce primary care practitioners and to provide health care in rural and underserved areas.

We are cognizant of the fiscal constraints within which the federal government and, indeed, all health care providers must operate. We recognize the necessity of controlling health care costs and pledge our cooperation in that effort. The osteopathic medical education community stands ready to assist Congress and the Administration during their efforts to ensure that federal health dollars are used to respond, in the most effective manner possible, to the health care needs and priorities facing us today. Thank you.

SUMMARY

This testimony reflects the perspective of the American Association of Colleges of Osteopathic Medicine and its member colleges. The osteopathic profession brings an important view to health care; its medical education and practice stress primary care, health promotion, and disease prevention. Over 80 percent of the osteopathic medical profession are engaged in the delivery of primary care services. More than half of the profession provide health care services to communities of less than 50,000 persons.

The historical recognition of medical education costs under medicare has contributed significantly to the development of a strong, qualified cadre of hospital-trained physicians in this nation. For the osteopathic medical education community in particular, because of its extensive reliance on training in small to moderate community hospitals, that reimbursement policy has been invaluable in our efforts to train significant numbers of primary care practitioners. Therefore, this profession was pleased that Congress chose to continue medicare recognition of medical education costs under prospective payment. We support the continuation of that reimbursement policy for the future.

Important information, vital to any policy recommendations regarding the current medical education financing mechanism under medicare, is not yet available. The period of time in which hospitals have operated under the new prospective payment system has been brief. It will be several years yet before the system is fully implemented. Further, while several efforts to define more specifically the parameters of graduate medical education have been initiated, that work is still underway. Consequently, we believe that any programmatic change in medicare reimbursement for medical education costs and any change in the levels of that reimbursement should wait until all pertinent information is available.

Finally, the osteopathic medical education community recognizes the potential for the federal government through such mechanisms as reimbursement policy, to encourage the development of specific, high-priority health care products. We urge the Subcommittee to regard both the current medical education financing mechanism and any future policy recommendations in light of their response to a changing health care scenario. There is an on-going need to develop a strong cadre of primary care practitioners as well as a cadre of physicians adept in providing services in such new health care environments as ambulatory care centers. We believe the federal government could, and should, make a positive impact on the medical education community's ability to respond to those needs through its medical education reimbursement policy.

STATEMENT OF DR. LOUISE FITZPATRICK, DEAN OF THE SCHOOL OF NURSING, VILLANOVA UNIVERSITY, VILLANOVA, PA, ON BEHALF OF THE NATIONAL LEAGUE FOR NURSING

Senator DURENBERGER. Dr. Fitzpatrick.

Dr. FITZPATRICK. Thank you, Mr. Chairman.

I am Louise Fitzpatrick, dean of the college of nursing at Villanova University, and I am speaking today on behalf of the National League for Nursing and the American Nurses Association.

The National League for Nursing is a nationally recognized accrediting body for nursing education and the American Nurses Association represents registered nurses through constituent State nurses associations.

With me is Ms. Sally Soloman from the National League for Nursing staff.

We appreciate the opportunity to present our views on the subject of Medicare's role in the financing of nursing education. As I am sure you know, members of both organizations have a strong interest in maintaining high standards of nursing education so that patients, many of whom are Medicare recipients, can receive the best nursing care possible.

Mr. Chairman, in the interest of time, I will present some salient features of our testimony, which has been submitted.

Since the enactment of Medicare 20 years ago, there has been a shift in nursing education programs which makes it necessary to reevaluate Medicare's policy on funding nursing education. In 1965, with the majority of nursing education programs being hospital-based, it was understandable that most of Medicare funds for nursing education went to these programs. However, between 1964 and 1983, the number of hospital-based programs has dropped more than 50 percent, while the number of nursing programs located in institutions of higher education has nearly tripled.

Today, students from basic nursing programs, located in institutions of higher education, comprise over two-thirds of all nursing graduations in contrast to the much smaller percentage that they represented 20 years ago. In addition, the number of masters nursing programs has increased from 56 in 1965 to 154 in 1983.

Despite these trends, the majority of Medicare funds for nursing education continues to be allocated to hospital-based programs. This is evidenced by HCFA's most recent statistics, which indicate that for 1979 Medicare spent approximately $135 million on nursing education, the majority of which went to hospital-based programs.

The allocation of Medicare dollars to finance nursing education does not accurately correspond to the distribution of the nursing student population. For nursing schools located in institutions of higher education, the greater fiscal pressure the hospitals are experiencing as a result of prospective payment systems has been a source of some concern. There has been discussions that schools might be billed for each nursing student that uses a hospital's clinical facility.

I know from firsthand experience and recent experience that nursing schools in the Philadelphia area were threatened by one hospital with a $100 charge per student for fall 1984, despite the

fact that the nursing schools place their own faculty in these facilities to provide instruction, using very low faculty-student ratios of approximately 1 instructor per 8 students, and to say nothing of the contributions which both students and faculty make to improving the quality of nursing care in the institution and to the development of the institution's nursing staff.

Although this $100 charge has been suspended for the time being, or at least until December, it left many concerns within the nursing community. If nursing schools are charged these fees, the extra financial burden will either force schools to close or to pass the cost along to the student in the form of higher tuition or fees which would certainly be a deterrent to student recruitment.

To our knowledge, there is no comparable movement afoot to charge undergraduate medical students in order to recover the clinical costs of medical education. The recent passage of a prospective payment system has raised questions regarding what should be recognized as direct educational costs for joint educational programs. By this I mean when a hospital is used as a clinical site for a nursing program, which is operated and financed by an institution of higher education.

Clarification is definitely needed regarding the definition and interpretation of these costs. This is closely linked with a second problem—lack of essential data. Estimates of direct nursing education costs are lacking for both individual hospitals and on a national basis.

Because we are so aware of this lack of data, the National League for Nursing is currently organizing a nationwide survey, the results of which we hope will help to identify more precisely the existing ways of recognizing and handling direct nursing educational costs.

Once these data are collected, we will probably be in a better position to understand the allocation of funds for nursing education, including those for Medicare. And we certainly will be pleased to share these data with you and your staff.

A final point to be clarified is the distinction that must be made between medical and nursing education programs as far as Medicare reimbursement is concerned. Interns and residents are graduate physicians and are employed and salaried by the hospital, whereas nursing students are undergraduates in large measure, and in addition, graduate students, who are in place in hospitals as part of their clinical practice for learning and for which they pay tuition.

Finally, although most of Medicare's funding for nursing education falls under direct costs, we also have some concerns about the prospective payment system's indirect adjustment for teaching hospitals. This proxy for higher costs associated with academic institutions is based on graduate medical positions and does not take into account the provision of clinical experience for nursing education programs. Hospitals without interns and residents, but with several nursing schools using their facilities for clinical placements, do not recover the indirect teaching cost of the nursing education program.

In summary, we consider Medicare funding for nursing education to be important, but the current methodology used to allocate the

Medicare dollars does not accurately reflect the changing trends in nursing education.

This ends my testimony, but we would be happy to answer any questions.

Senator DURENBERGER. Thank you.

[The prepared written statement of Dr. Fitzpatrick follows:]

Testimony of the National League for Nursing

and the

American Nurses' Association

before the

U.S. Senate Finance Committee

Subcommittee on Health

October 1, 1984

Mr. Chairman, I am Dr. Louise Fitzpatrick, Dean of the School of Nursing at Villanova University. I am speaking today on behalf of the National League for Nursing (NLN) and the American Nurses' Association (ANA). NLN is the nationally recognized accrediting body for nursing education and is one of the largest coalitions of health care professionals, practitioners and consumers dedicated to providing quality health care. It includes 2,000 agency members and 17,000 individual members residing in constituent leagues throughout the country. ANA represents 185,000 registered nurses through 53 constituent state nurses associations.

Summary of Remarks by the National League for Nursing
and the American Nurses' Association

for Hearings on Medical Education Funding by the Medicare Program

For the U.S. Senate Finance Committee
Subcommittee on Health
October 1, 1984

I. Changing Trends in Medicare and Nursing Education

Medicare policy for funding nursing education needs to reflect more accurately the shift in nursing education whereby the majority of the nation's nursing programs are located in institutions of higher education, as opposed to 20 years ago, when they were mostly hospital-based diploma programs.

II. The Impact of Cutbacks on Nursing Education

In an era when hospitals are under greater fiscal pressure, nursing programs located within institutions of higher education are concerned that hospitals, where their students are placed for the clinical portion of their education, will charge the schools a fee for each student in order to generate revenues. This would place an unnecessary burden on nursing schools and nursing students, many of whom are already finding it difficult to make financial ends meet.

III. Need for Policy Clarification and Additional Data

Passage of the prospective payment system has raised questions as to what should be recognized as allowable direct nursing educational costs. Clarification is needed regarding the definition and interpretation of these costs. There is also a need for more data regarding these costs on behalf of individual providers and the federal government. The effect of a direct pass-through or any other financing mechanism cannot be assumed to be the same for both medical education and nursing education.

IV. Hospital-Based Nursing Programs

Hospital-based nursing education programs, which are highly dependent upon Medicare funding, are concerned that their educational costs might not be fully recognized either through the direct pass-through or indirect adjustment under prospective payment. The growth of single-purpose degree granting institutions has also raised questions regarding allowable direct educational costs.

V. Indirect Costs

This proxy for the higher costs associated with academic teaching institutions is based on graduate medical positions and does not take into account the provision of clinical experiences for nursing educational programs.

We appreciate the opportunity to present our views on the subject of Medicare's role in the financing of nursing education. Members of both organizations have a strong interest in maintaining high standards of nursing education so that patients, many of whom are Medicare recipients, can receive the best nursing care.

CHANGING TRENDS IN MEDICARE AND NURSING EDUCATION

Since Medicare was first enacted in 1965, the health care system has witnessed significant changes. One major area of change has been in the assumptions underlying the use of federal funds to finance education for health care professionals. In the sixties, the shortage of physicians and nurses was, in part, the rationale behind Medicare's commitment to providing its share of funding for health professionals' education. The federal government also made its contribution through generous funding for training of health care professionals under the Public Health Service Act.

Today, mostly due to the allocation of federal monies, the shortage of physicians and nurses has abated. Nonetheless, because of Medicare's interest in maintaining an adequately prepared cadre of health care professionals and its recognition of the absence of community resources to meet these needs, Medicare continues to contribute a certain amount of money to the financing of health professionals' education through its payment for services.

Regarding these educational costs, it was the original intent of Medicare that the burden for educating health professionals be borne as much as possible by the community and not by patient care dollars. However, since in most cases the community has not assumed this responsibility, Medicare has

agreed to pay its share of the cost of educational programs in provider institutions.

The Medicare cost reimbursement system requires that reimbursement can be made only for education occurring in hospital settings. As a result, most of the costs of hospital-based nursing education programs are reflected in the hospital cost report, while the allowable costs of nursing education programs operated outside of hospitals are limited to the cost of the clinical component.

As you know, in 1983 Congress enacted the prospective payment system which replaced Medicare's cost-based reimbursement system previously in effect. The result of this new system is to provide hospitals with a fixed price for in-patient services according to diagnoses and a separate cost-based payment for education and capital expenses. For nursing, this has raised two important questions: 1) Does the definition of direct educational costs sufficiently recognize all of the direct costs of nursing programs in the clinical setting? 2) Do the DRG rates adequately cover the indirect costs of nursing education?

Assumptions underlying the allocation of Medicare funds for nursing education have been based on the universe of nursing education programs at the time when Medicare was first enacted--20 years ago. Since then, nursing education has undergone dramatic changes and the Medicare program has undergone significant changes as well.

For example, 20 years ago the majority of the nation's nursing schools were hospital-based diploma programs. Hence, it was appropriate at that time that the majority of funds for financing nursing education be

allocated to programs with the largest proportion of nursing students--namely, diploma programs. This trend of allocating the majority of Medicare's funds for nursing education to diploma schools has continued today. The Health Care Financing Administration's (HCFA's) most recent statistics indicate that for 1979, allowable nursing education costs were approximately $350 million for all providers participating in Medicare. Assuming an average 38% Medicare hospital utilization rate, Medicare's share of the cost of nursing education was estimated at $133 million, the majority of which went to diploma programs.

However, since 1965, the focus of nursing education has shifted from hospital-based diploma programs to institutions of higher education. The number of diploma programs has dropped more than 50%--from 813 to 281, while the number of nursing programs located in institutions of higher education has increased from 369 to 1,185 (421 baccalaureate and 764 associate degree programs). The shift in the locus of nursing education programs is accentuated by the proliferation of nursing programs and the more than doubling of the number of graduates from basic nursing programs. (See Appendix.)

The demand for college-based nursing education can also be attributed to the growing number of diploma graduates who are returning to school for a baccalaureate degree in nursing. In addition, over the past 20 years, there has been a large increase in the number of master's nursing programs (56 in 1965 compared with 154 in 1983).

With the huge increase in the number of students in nursing programs located in institutions of higher education, Medicare dollars do not reflect the developments in nursing education.

THE IMPACT OF CUTBACKS ON NURSING EDUCATION

Under the prospective payment system, the pressure on hospital budgets has greatly intensified. This has coincided with, and in part has been a result of, a 6.3% drop in national hospital occupancy rates and a decrease in the average length of stay for Medicare hospitals from 9.5 days to 7.5 days since October 1983. With hospitals bringing in fewer patient care dollars, there is growing pressure to save money and generate revenues in whatever way they can.

As a result, many of the nation's nursing programs located in institutions of higher education are faced with the possibility of being billed for each nursing student that uses a hospital's clinical facilities. Already, nursing schools in Philadelphia were threatened by one hospital with a $100 charge per student for fall 1984. Although the charge has been suspended, it raised many concerns within the nursing community. If nursing schools are charged these fees, the extra financial burden will either force schools to close or to pass the costs along to the student in the form of higher tuition or fees. Many nursing schools already operate under severe budget cuts and decreased federal funding. Adding this cost would not only be a huge financial burden, but would also be a deterrent in terms of student recruitment and enrollments. To our knowledge, there is no comparable movement afoot to charge undergraduate medical students in order to recover the clinical costs of medical education.

NEED FOR POLICY CLARIFICATION AND ADDITIONAL DATA

Passage of the prospective payment system has raised questions throughout the nursing community as to what should be recognized as allowable

direct educational costs for joint educational programs (i.e., when a hospital is used as a clinical site for a nursing program operated fully or in part by an institution of higher education). However, controversies in this area are not new. In the past, the Provider Reimbursement Review Board (PRRB) held that many of the costs associated with joint educational programs should be allowed because the provider is engaging in an educational activity in line with Medicare regulations and the programs enhance the quality of care in the hospital.

On the other hand, the Commissioner of Social Security and the Administrator of HCFA have argued that these costs should not be allowed. They stated that it was not the legislative nor regulatory intent of Medicare to pay for educational programs, except when the provider is the "legal operator" of the program.

In a landmark case (St. John's Hickey Memorial Hospital, Inc. vs Califano), the Seventh Circuit Court of Appeals sided with the PRRB and subsequently many of the clinical costs which are part of joint educational programs are now recognized by Medicare.

Given that these costs are allowed, there has not been consistency among nurse educators, hospital administrators, and intermediaries in defining what they should comprise. For example, one hospital that associated with the nursing programs of two educational institutions was able to include in allowable costs the net cost of maintaining a dormitory for the nursing students. In another case, payments by a hospital to a junior college for the support of a nursing education program were not allowed, even though it was operated by and under the control of the same organization. There must be clarification regarding the definition of allowable direct nursing education costs for joint educational programs.

The need for clarification is closely linked with a second problem--lack of essential data. Estimates of direct nursing educational costs are lacking for both individual hospitals and for national aggregates. For example, hospitals have not been in the practice of itemizing the Medicare costs for each of the nursing schools that use the hospital for clinical placements. Nor do hospitals routinely estimate the percentage of the nursing staff's time, salaries and budgets that are indirectly allocated to nursing educational costs in either working with or arranging for nursing students. In one hospital study, these unaccounted costs totaled over $2 million.

When figures are available (such as the estimate that for 1979 Medicare spent nearly $135 million for nursing education), their accuracy must be questioned due to the different interpretations of cost reporting practices and the variations in what is ultimately defined as allowable. This could result in an underestimate of the nursing educational costs under Medicare.

NLN is currently organizing a nationwide survey, the results of which will help to identify more precisely the existing ways of recognizing and handling the direct nursing educational costs. Once these initial data are collected, we will be in a better position to understand the allocation of funds for nursing education, including those from Medicare. We will be pleased to share these data with you and your staff.

One final point requiring clarification is the distinction that must be made between medical and nursing educational programs insofar as Medicare reimbursement is concerned. Medical interns and residents are graduate physicians, salaried by the hospital for the services they provide as part of their training. In contrast, nursing students are placed in hospitals for the clinical component of their undergraduate education and their clinical

experience is geared primarily towards learning and not towards providing services for the hospitals. Undergraduate medical education also differs from nursing in that for the most part, medical education programs follow one general model and confer the same degree. In contrast, preparation for nursing education can be obtained through several routes, differing in length and setting.

Hence, the effect on nursing education of a direct pass-through, or of any other financing mechanism, cannot be assumed to be the same as that on medical education. Nor can the impact be assumed to be the same for each type of nursing program because of the wide variation in the relationships between nursing educational institutions and the hospitals which serve as Medicare providers.

HOSPITAL-BASED NURSING PROGRAMS

The survival of hospital-based nursing educational programs is highly dependent on Medicare dollars. The fiscal restraints that hospitals are experiencing has also had an impact on these programs

Under prospective payment, directors of hospital-based nursing programs are concerned that their educational costs might not be fully recognized either through the direct pass-through or the indirect adjustment. Additionally, most of the costs related to the clinical portion of a hospital-based nursing program are recovered by the department where the nurses received their clinical experiences, rather than in the nursing school cost center. Hence, the costs of these students' education are not identified as educational costs for the nursing school, but as part of the hospital's budget for each department.

For hospitals, the interpretations of the hospital-based cost report instructions vary widely with respect to the allocation of educational costs. As a result, providers and intermediaries view nursing educational costs in different ways and the inconsistent treatment of the costs included in the nursing school cost center makes it difficult to compare data.

Finally, with changing trends in nursing education, a number of hospital-based programs are contracting with institutions of higher education to become single-purpose degree granting institutions that confer associate and/or baccalaureate degrees. The rapidly increasing number of these programs has raised questions regarding the reimbursement of direct costs. There is concern as to whether Medicare will reimburse hospitals for the clinical experiences of these students. Recently, a nursing program under the auspices of both a liberal arts college and a hospital arranged that the salaries for the nursing faculty and their support staff be considered a direct nursing educational cost, and thereby receive Medicare reimbursement on a pass-through basis. However, this case is not necessarily typical. There are other arrangements where educational costs have been disallowed.

INDIRECT COSTS

Most of nursing education funding under Medicare is via the direct pass-through. Some of the other costs fall under the indirect adjustment, which is a proxy for the higher costs associated with academic teaching facilities. The indirect adjustment, based on a ratio of the number of interns and residents to hospital beds, is intended to cover the extra costs of other health professions' education, such as nursing, physical therapy, dietary and radiology technicians; academic teaching hospitals; and the more severely ill patient mix typically found in teaching hospitals.

Insofar as the indirect adjustment is based on graduate medical education positions, it does not take into account the impact of nursing education programs. There is hardly any correlation between the number of nursing students placed in a hospital and the number of interns and residents in the same institution. For example, a large metropolitan hospital in New York City is affiliated with a medical school and has as many as 500 nursing students using its facilities. The indirect costs of this nursing program are covered under the indirect medical expenses. In contrast, many hospitals in one rural southwestern state offer clinical placements for at least three nursing programs, as well as programs for other health professionals, while having no formal affiliation with the state's only medical school. These hospitals have no way of recovering the indirect costs of the nursing education programs. In fact, there is very little data which identify the indirect costs for nursng education, or for any of the other allied health professionals.

SUMMARY

In summary, Medicare funding for nursing education does not accurately reflect the changing trends in nursing education since the enactment of Medicare 20 years ago. There is need for clarification regarding the direct pass-through for joint educational nursing programs and need for an objective approach in dealing with all types of nursing educational programs. Especially in light of current cost containment efforts under prospective payment, more extensive data collection on behalf of both individual providers and HCFA will be essential.

On behalf of the NLN and the ANA, we thank the committee for allowing us to present our views. The nursing community is willing to assist your committee in any way we can.

APPENDIX

BASIC RN EDUCATIONAL PROGRAMS AND GRADUATES

1964-65 and 1982-83

		1964-65	1982-83
Number of Programs		1,182	1,466
Number of Graduates:	Total	34,497	77,408
	Baccalaureate	5,376	23,855
	Associate Degree	2,510	41,849
	Diploma	26,611	11,704

Senator DURENBERGER. Did I hear you say that nursing students are in the hospital setting as part of their education, and don't provide services while they are there? Is that accurate?

Dr. FITZPATRICK. Partially.

Senator DURENBERGER. Tell us what they do.

Dr. FITZPATRICK. Nursing students who come from collegiate programs are placed in the hospital for clinical practica. In fact, they are there for a short number of hours. They are using the environment as a setting to apply theoretical knowledge learned in the classroom. And it is through the vehicle of patient care. Perhaps 75 percent of that practice time is through the vehicle of patient care.

Senator DURENBERGER. Seventy-five percent of it is—I'm wondering what benefit the hospital gets from the presence of these students.

Dr. FITZPATRICK. I believe, Mr. Chairman, that it does have an impact on their staffing, although we do not have the data to support this. It is my observation that staffing patterns do change when students are in an institution. In fact, staff may be pulled off units for inservice education activities. There may be changes in staffing patterns on days when students are present and caring for patients as part of their education.

Senator DURENBERGER. To carry that one step further, the indirect medical education adjustment we created to deal with the added costs that might be incurred during graduate education of physicians wasn't created to address the extra costs of other education programs. But you raised a point in your testimony and that is to what extent the indirect costs of other educational programs are covered in some way by this adjustment. Can you give me any examples of indirect costs associated with nursing education?

Dr. FITZPATRICK. The one that comes to mind immediately is perhaps the use of space for conferencing students within the hospital facility while students are there for clinical practica. The other one that possibly could be considered is the time spent by hospital staff in coordinating and assigning various schools to units within the hospital for the purpose of student education.

However, we believe that this is offset by the contributions that the students and the faculty are making while they are in the facility. And we have never attached a cost to this or a pricetag to it. Certain kinds of consultation are being delivered free from the faculty. And as I said, the students are paying tuition to the universities for the opportunity to study.

Senator DURENBERGER. Dr. Cohen, let me revisit your bottom line for the colleges of osteopathic medicine. I heard you say that osteopathy has a very substantial contribution to make in this country. That it is part of—what I noted here, and I don't know whether you actually said it but there is a shifting to primary care, ambulatory settings, that sort of thing. And yet you said, "Don't touch the system the way it is now until you have something better to replace it with." And my impression of the current system is that it is going to continue to produce what it is producing right now. And that the only way it's going to produce more primary care professionals and some of these other things that you may think we need is if the public health service has specific programs or they are pushed in some way.

Why would you want to maintain a reimbursement system that continued that kind of emphasis on specialization in medicine?

Dr. COHEN. Mr. Chairman, as you said, I recommended keeping that system until the facts are in because I would be afraid to throw the baby out with the bath water. I think that that system certainly has produced for us, a quality educational system that is without peer in the world.

What I think is going to evolve in the last part of this decade and perhaps in the early part of the next decade, is that competition and the competitive forces will prove part of the case that you can practice good medicine in a setting where the morbidity and mortality isn't any worse than in the traditional settings. I think under such a system you are going to find that much health care in America can be done in ambulatory settings. We are already moving that way. I don't know of a hospital or an area that hasn't set up outpatient surgical care centers and various ambulatory services.

Some centers admittedly are fostered by profit. On the other hand, I think it has awakened all of us to the fact that good medicine can be practiced in an area outside of the hospital. I think that all of medicine will look at this and eventually lean toward greater programming outside of the hospital. What concerns me is that under the current reimbursement we have no real mechanisms for funding medical education under those circumstances. And what I humbly suggested is that when changes are made in the future, as I am sure that they will be, that some change should be made in that direction. I think this country needs more primary care practitioners who are trained in ambulatory settings rather than in tertiary care. Ali do not have to be trained in the most expensive type of medicine.

I certainly think there is a need to continue those tertiary centers.

Senator DURENBERGER. All right.

Dr. Chapman, let me ask you, especially with your Vanderbilt hat on, to try to address the same kind of question that I raised, and I raised it in a different form in the last question to the previous panel: Aren't we educating too much perhaps? And now asking it in a sort of a different sense. Isn't there a different demand out there?

And I don't know where your students are going down there, but I do know that in that part of the country there is an awful lot of competition. I'm curious to know your personal views about whether or not medical education is keeping up, that is, the educational institutions. What they are demanding of their students and what they are pumping into them, and the product they are turning out at the end. Is that still relevant to what you see out in the practice of medicine the way it is being practiced in your particular area?

Dr. CHAPMAN. Senator, I believe, if I might interpret your question, it's three questions. What are we doing to change circumstances in a meaningful way that's positive and that we can manage? Second, what are we doing internal to the individual schools that determine that we are at the leading edge of what physicians must know? And, finally, how are we determining that so that we don't carry forward that which is not needed?

Senator DURENBERGER. Extremely well put. I hope somebody made notes on that. [Laughter.]

Dr. CHAPMAN. Well, that was the subject of a faculty meeting. [Laughter.]

I may just provide you the comments of the faculty meeting. It is a serious problem for we have a marvelcus way of carrying forward that of the past not needed in the present. The comments earlier that you made and that were responded to by the administrative representatives are relevant here.

I can tell you what we are doing. We have a regular program that is the core program of the institution. Most but not all faculty agree that this is what the students should carry forward with them. We have an experimental program. An experimental program is here today and it can be gone tomorrow if it is unsuccessful in the eyes, as in our case, of a committee of the faculty.

We have an innovative part to the program. And innovative part such that the innovative program is different from the experimental. The innovative program has been through experimental and is new. If we put something in the innovative program we have got to find something in the regular program that can be reduced at least somewhat. And that is where the cheese begins to bind. Medical schools use money and time in the curriculum as the coins of the realm.

When one cuts into the regular program, one is cutting into a set of circumstances important to an individual faculty member.

Now expressly to respond to your question—are we addressing enough or are we addressing it properly when some feel it's too much. I think we are. There is more going on right now in medical education in the review of curriculum and in the review of what is necessary to be a physician today that I have ever seen in some 23 years as one form of dean or another.

Senator DURENBERGER. Describe that, if you can, briefly for me. And also the role that physicians are playing in that outside of the medical faculties.

Dr. CHAPMAN. As recently, I think, as last week or in the preceding 2 or so weeks, a study was released by the Association of American Medical Colleges, known as GPEP [graduate and professional education of physicians.] This was the result of a long-term review by medical educators and faculties as to what is the substance of medical education and how to go about refining that substance so it fits better.

Every medical school in the country will be looking at this as it relates to each. As soon as, I think, Wednesday or Thursday of this week, the southern deans are meeting in Houston to examine what is it in that program that is relevant to us and what do we have that is not relevant to it. I think the fundamental principle that the program of the school is the function of its faculty is valid. I think there is more going on right now in medical education in relationship to what is appropriate, what is inappropriate, what is too much and what is not enough that I have seen previously.

Senator DURENBERGER. Is it going on all over the country or is it the southern deans or what is it?

Dr. CHAPMAN. Well, we don't plan to secede.

Senator DURENBERGER. Well, it might be a good idea if you did. [Laughter.]

You are probably going to put a lot of the rest of those schools out of business.

Dr. CHAPMAN. This is going on all over the country. The deans meeting of the group in the South is simply upcoming, and most immediately adjacent to the release of the study.

This is going on nationwide. The experiments at Harvard with reference to the 25 students in their special programs. The experience at Hopkins. Duke's experience. Stanford's experience. Those are all programs that have the rest of us intensely interested.

There is another factor and that's the students. Students are paying a good bit now to go to medical school, as we have learned. They are becoming rather discriminating in what they get when they go. Back in the early part of this century when I went to medical school, one was like another. But that isn't the case now.

Senator DURENBERGER. Can you describe for me, before you finish, the AMA's role in the accreditation process for medical schools and all that as it relates to what you have been testifying to?

Dr. CHAPMAN. Yes. Accreditation of a medical school is a voluntary act on the part of the school. The school invites review. The accreditation or the accrediting agency for undergraduate medical education is the LCME, [Liaison Committee on Medication Education.] It is liaison because it is a combined group of AAMC representatives and AMA representatives. That group meets to review the reports of on site examination of the program, students, and faculty of every medical school in the country on a periodic basis.

The reports of the site visitors are reviewed by the LCME. The LCME takes action to provide accreditation for a particular period of time. The maximum period is 10 years. The minimum period is a matter of weeks or months.

Senator DURENBERGER. Well, we are going to have to keep moving. I just want to indicate to all of you and the associations that you represent that we need you a lot for the next hearing. Each of you comes from a slightly different perspective here, but you are the consumers of the products of these institutions that we have been talking about, and you are also the people that the American people are looking to to satisfy their particular needs. So when we get to viewing this system from the standpoint of what the consumer needs and is getting, we are going to need to hear from all of you again.

So I appreciate very much the help you have been to us today, and look forward to your testimony the next time.

Thank you very much.

Senator DURENBERGER. The final panel consists of: David L. Everhart, president, Northwestern Memorial Hospital, Chicago, IL, on behalf of the American Hospital Association; and Richard J. Minor, president of the Grandview Hospital of Dayton, OH, on behalf of the American Osteopathic Hospital Association.

Gentlemen, I thank you for your patience.

I now have both of your statements in hand. I have had a chance to read Dave's, but I guess, Bob, yours got in late or something and I didn't have a chance to read it. But both of the written state-

ments will be made part of the record. You may proceed to summarize them in any way, including, since you have been here for the last 2 hours and 20 minutes, any specific comments you may want to have from your own particular view, looking at it from the users of some part of this system. You may react to some of the questions that I have raised or some of the comments that have been made by some of the previous witnesses.

And, Dave, let me say your reputation has preceded you for some reason around here. And we are looking forward to great things from you in your 10-minute presentation.

STATEMENT OF DAVID L. EVERHART, PRESIDENT, NORTHWESTERN MEMORIAL HOSPITAL, CHICAGO, IL, ON BEHALF OF THE AMERICAN HOSPITAL ASSOCIATION, WASHINGTON, DC

Mr. EVERHART. Well, thank you, Mr. Chairman. I'm Dave Everhart, president of the Northwestern Memorial Hospital. It is a 950-bed teaching hospital in Chicago, IL. Parenthetically, the purveyor of medical care services to the Chicago Cubs. I thought I would throw that in.

I'm pleased to be here this afternoon on behalf of the American Hospital Association to present its views on the financing of graduate medical education.

And with your permission, I am going to shorten this presentation somewhat in the event you might have some questions you would like to throw at me.

Senator DURENBERGER. You are the one that gave me the notion here that it's important to recognize that the costs of training are absorbed not by the communities in which they eventually are located, but by communities and institutions where the physicians train.

Mr. EVERHART. Right.

Senator DURENBERGER. Can you start right with that?

Mr. EVERHART. Why don't I just give you my formal presentation?

Senator DURENBERGER. All right.

Mr. EVERHART. They paid me to come from Chicago to do that. [Laughter.]

Paid my expenses, excuse me. [Laughter.]

Actually, they may not do that after this performance.

Senator DURENBERGER. But they will get you back in time for the game tomorrow.

Mr. EVERHART. Right. Absolutely.

In economic terms, graduate medical education is a hospital product, along with patient care. In practical terms, it's difficult to differentiate between those costs associated with education and those costs associated with patient care.

Medical education makes a substantial contribution both to patients treated in teaching hospitals and, obviously, to society. Because of their traditional educational mission, teaching hospitals have access to the most recent medical knowledge and technology,

and to the broadest array of medical specialists. Consequently, teaching hospitals have become institutions to which the most severely ill patients and those with the most baffling conditions are referred.

Many of the most significant advances in medical practice and technology can be traced to teaching hospitals. Moreover, teaching institutions are the primary facilities where physicians who eventually practice in communities of other hospitals across the country receive their most intensive clinical training.

It's too soon to determine if the policies adopted by Congress in 1983 will appropriately compensate for the cost of graduate medical education in the more complex and severely ill case mix of teaching hospitals. Because many teaching hospitals have been operating under the DRG system for less than 3 months, they have not been able to assess the financial impact of the new system on their institutions.

While it appears that current policies are working reasonably well at this preliminary stage, several problems have surfaced that are outlined in our written statement.

The AAHA believes Medicare payment policies for the cost of graduate medical education should be guided by several basic principles. First, Medicare, as any other payer, should pay its proportionate share of both direct and indirect cost of medical education. Unless Medicare and the other payers recognize this responsibility, teaching hospitals will not be able to compete effectively in an increasingly competitive market. In fulfilling this responsibility, it must be recognized this contribution will be vital in determining the overall level of support for medical education in this country.

Second, Medicare policy should recognize the value of medical education to patients, Medicare beneficiaries and the public at large. Failure to adequately support these institutions will seriously jeopardize continued progress in medical science and practice.

Third, Medicare policies should recognize that at least some of the costs associated with graduate medical education cannot be easily identified. Every effort should be made to more adequately account for the real differences in hospital case mix in refining the DRG system.

And, fourth, Medicare policy should not produce unfair shifts in the distribution of revenues among hospitals. While some reallocation may be appropriate, it should reflect differences in efficiency and not differences in the types of patients treated in different hospitals. Major reallocations are likely to be the result of imperfect knowledge or data and will be highly unstable as the quality of data improves.

Mr. Chairman, hospitals with graduate medical education programs play a pivotal role in the training of physicians and in exploring the frontiers of medical research. Moreover, these institutions provide highly sophisticated health care services. Providing proper planning and financing for graduate medical education is crucial to maintaining the highest quality health care in this Nation.

We look forward to working with you and with the subcommittee in developing a fair and equitable policy that addresses these

issues. Obviously, I would be glad to try to answer some of your questions.

Senator DURENBERGER. Thank you very much.

[The prepared written statement of Mr. Everhart follows:]

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STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION
BEFORE THE SUBCOMITTEE ON HEALTH
OF THE COMMITTEE ON FINANCE
ON FINANCING MEDICAL EDUCATION

October 1, 1984

SUMMARY

Though one of the primary purposes of teaching hospitals is to train physicians, these institutions also play other important roles in the health care delivery system, serving as referral and tertiary care centers in which the most difficult medical cases and most severely ill patients are treated. Therefore, costs in teaching hospitals are consistently higher than in their non-teaching counterparts. Other reasons for higher costs associated with these institutions include: the direct costs of educational programs; case-mix differences not reflected in diagnosis-related groups (DRGs); the effect of educational programs on length of stay and ancillary services utilization; and the availability of highly specialized services not found in non-teaching community hospitals.

A policy on Medicare payment for graduate medical education should be based on four principles:

- as any other payer, Medicare should contribute its proportionate share of the costs of graduate medical education;
- Medicare should recognize the value of graduate medical education to Medicare patients as well as to the public at large;
- Medicare should recognize that at least some of the costs associated with graduate medical education cannot be identified; and
- Medicare payment policies that recognize costs associated with graduate medical education should not produce radical shifts in the distribution of revenues among hospitals.

Policies that are not consistent with these principles could lead to potentially serious reductions in the services that are available to patients, Medicare beneficiaries, and the general public.

INTRODUCTION

Mr. Chairman, I am David Everhart, president of the Northwestern Memorial Hospital, a 947-bed teaching hospital in Chicago, Illinois, that is affiliated with Northwestern University Medical School. I am pleased to be here on behalf of the American Hospital Association (AHA) to present its views on financing graduate medical education. The Association represents over 6,100 member hospitals and health care institutions, as well as more than 38,000 personal members.

The committee has indicated that it would like to address three issues:

- the adequacy and appropriateness of Medicare's current payment policies in regard to the recognition of graduate medical education costs;
- the potential, or actual, problems with and benefits of Medicare's current policies; and
- the objectives that should guide Medicare's policies on payment for the costs of graduate medical education.

An understanding of the nature of graduate medical education costs is essential if we are to properly address these issues. In economic terms, graduate medical education is a hospital product, along with patient care. In practical terms, it is difficult to differentiate between those costs

associated with education and costs associated with patient care. Because patient care and educational costs are inseperable, Medicare traditionally has reimbursed for costs associated with graduate medical education as well as for patient care costs. This policy is both a practical necessity and, more important, appropriate from the perspective of the public interest. As we move toward a fully implemented prospective pricing system, it will be important that we not interrupt funding for educational activities, and recognize that the Medicare payment system influences the determination of appropriate levels of medical training.

CONTRIBUTION OF MEDICAL EDUCATION

Medical education makes a substantial contribution both to patients treated in teaching hospitals and to society. Because of their educational mission, teaching hospitals have access to the most recent medical knowledge and technology and the broadest array of medical specialists. Consequently, teaching hospitals have become institutions in which the most severely ill patients, and to which the patients with the most baffling conditions are referred. Many of the most significant advances in medical practice and technology can be traced to teaching hospitals. Moreover, teaching institutions are the primary facilities where physicians who eventually practice in communities and other hospitals across the country receive their most intensive clinical training. It is important to recognize that the costs of this training are absorbed not by the communities in which physicians eventually locate, but by the communities and the institutions in which the physician trains.

COSTS OF MEDICAL EDUCATION

For many years, researchers, hospital administrators, and those involved in the development of health policy have attempted to identify and isolate the "costs" of graduate medical education. Clearly, costs in teaching hospitals are consistently higher than in non-teaching hospitals. Part of that difference can be readily identified as stipends for interns and residents, and wages and salaries for faculty. But, after accounting for these costs, substantial differences remain. The factors that contribute to this discrepancy include:

- longer lengths of stay, more intensive use of ancillary services, and higher staffing levels resulting from the training of interns and residents;

- longer lengths of stay, more intensive use of ancillary services, and higher staffing levels resulting from differences in the mix of patients treated in teaching versus non-teaching hospitals;

- differences in the apparent "efficiency" with which special unit and regionalized resources are used--for example, "idle" time or "standby" capacity for particular technologies; and

- differences in wages and prices paid for other resources stemming from greater skill levels or location.

Most of these factors are related to differences between the case mixes of teaching hospitals and non-teaching community hospitals. Though the DRG system currently used by the Medicare program is intended to measure differences in case-mix, substantial evidence is accumulating that many case-mix differences are not reflected in DRGs. Until these variatons can be measured, it will be difficult, if not virtually impossible, to accurately pinpoint the costs of graduate medical education.

CURRENT MEDICARE POLICY

The costs of graduate medical education are treated in two separate components under current Medicare policy: direct costs and indirect costs. Direct costs include the salaries and stipends of faculty and house staff enrolled in residency training programs, as well as the overhead costs associated with these programs. Indirect costs include the higher patient care costs that result from residency training, such as longer hospital stays, more intensive use of ancillary services, and higher staffing levels. The adjustment for indirect medical education costs is designed to cover these costs as well as other costs that are not fully compensated by the DRG system.

When Congress designed the prospective pricing system, both the direct and the indirect costs of medical education were recognized. Medicare's share of the direct costs is reimbursed to the hospital, and a special allowance based on

the relative size of the hospital's teaching program provides reimbursement for the indirect costs. The direct education cost pass-through is relatively well established and appears to adequately recognize the direct costs of graduate medical education, as it has for the past 10 years. The indirect education allowance is more troublesome.

In implementing the system of cost-per-case limits created by the Tax Equity and Fiscal Responsibility Act of 1982, P.L.98-248, the Health Care Financing Administration (HCFA) estimated that costs increased by 6.06 percent for each increment of 0.1 in the ratio of interns and residents to beds. In other words, HCFA estimated that costs in a 500-bed hospital that had 50 interns and residents would be 6.06 percent higher than in a non-teaching hospital. This adjustment was part of the Administration's original proposal for a Medicare prospective pricing system: the DRG prices paid to a teaching hospital would have been raised by 5.8 percent for each increment of 0.1 in the ratio of interns and residents to beds.

A Congressional Budget Office (CBO) analysis of this proposal, however, indicated that such an adjustment would be inadequate, and that most teaching hospitals would have operated at a loss under this system unless substantial reductions in costs were achieved. Two key points were raised by CBO's analysis:

- the higher costs of teaching hospitals were the result of a higher level of severity of illness among the patients treated in those institutions--differences that the DRG system did not adequately reflect; and

- the reduction in costs that would be required to operate under the Administration's proposal would result in the elimination of many needed specialty services.

The solution adopted by Congress to address this problem was to double the indirect education factor proposed by the Administration and to establish separate price schedules for urban and rural hospitals. The doubling of the indirect education factor substantially reduced the penalty that teaching hospitals would have suffered, making the adoption of uniform national pricing appear more feasible.

ASSESSMENT OF CURRENT POLICIES

It is too soon to determine if the policies adopted by Congress in 1983 will appropriately compensate for the costs of both graduate medical education and the more complex and severely ill case-mix of teaching hospitals. Because many teaching hospitals have been operating under the DRG system for less than three months, they have not yet been able to assess the financial impact of the new system on their institutions.

While it appears that current policies are working reasonably well at this preliminary stage, several problems have surfaced.

- Although relatively few teaching hospitals are located in rural areas, those few are heavily penalized by Medicare's urban/rural price differences despite the indirect education factor. This arbitrary penalty stems from the typical rural hospital's operating 50 or fewer beds and not offering the comprehensive scope of services found in a teaching facility. In fact, many small, rural hospitals depend on rural teaching hospitals as a source of care for patients who require referral for specialized services. Provisions of the recently enacted Deficit Reduction Act of 1984, P.L.98-369, attempt to address this issue and should solve many of these problems.

- Because a substantial part of the teaching adjustment stems from case-mix differences not reflected by DRGs, teaching hospitals with high severity levels, but relatively small teaching programs, are not adequately compensated by the current policy. Moreover, non-teaching institutions that serve as referral hospitals and treat severely ill patients, and have case mixes comparable to those of their teaching counterparts, do not benefit from the education adjustment. Therefore, these hospitals receive unfairly low payments for not having educational programs.

- The teaching factor is based on the costs of an "average" teaching hospital. Those hospitals with education programs or hospital case mixes that differ substantially from the "average" teaching hospital's will receive an adjustment that does not necessarily reflect their legitimate costs.

OBJECTIVES FOR EDUCATION POLICIES

The AHA believes Medicare payment policies for the cost of graduate medical education programs should be guided by [illegible] principles:

- First, Medicare, as any other payer, should pay its proportionate share of both direct and indirect medical education costs. Unless Medicare and other payers recognize this responsibility, teaching hospitals will not be able to compete effectively in an increasingly competitive market. In fulfilling this responsibility, it must be recognized that this contribution will be vital in determining the overall level of support for graduate medical education in this country.

- Second, Medicare policies should recognize the value of graduate medical education to patients, Medicare beneficiaries, and the public at large. Academic medical centers are the institutions where new technology is developed and often serve to diffuse new medical knowledge throughout the country. Failure to adequately support these institutions will seriously jeopardize continued progress in medical science and practice.

- Third, Medicare policies should recognize that at least some of the costs associated with graduate medical education cannot be easily identified. Every effort should be made to more adequately account for real differences in hospital case-mix in refining the DRG system.

- Fourth, Medicare policies should not produce unfair shifts in the distribution of revenues among hospitals. While some reallocation may be appropriate--it should reflect differences in efficiency and not differences in the types of patients treated in different hospitals. Major reallocations, however, are likely to be the result of imperfect knowledge or data, and will be highly unstable as the quality of data improves.

If these principles are not kept in mind as the effects of current policies are evaluated, the consequence may well be the denial of certain costly, but valuable, services to many communities.

CONCLUSION

Hospitals with graduate medical education programs play a pivotal role in the training of physicians and in exploring the frontiers of medical research. Moroever, these institutions provide highly sophisticated health care services to patients, Medicare beneficaries, and the general public. Providing proper financing for graduate medical education is crucial to maintaining the highest quality health care in this nation. The Association looks forward to working with this subcommittee in developing a fair and equitable policy that addresses the issues we have outlined.

STATEMENT OF RICHARD J. MINOR, PRESIDENT OF THE GRANDVIEW HOSPITAL, DAYTON, OH, ON BEHALF OF THE AMERICAN OSTEOPATHIC HOSPITAL ASSOCIATION, WASHINGTON, DC

Senator DURENBERGER. Mr. Minor, welcome.

Mr. MINOR. Thank you, Mr. Chairman.

I'm Richard Joseph Minor, president and chief executive officer of Grandview Hospital, a 452-bed osteopathic teaching hospital in Dayton, OH, not too far from Chicago. I'm also president and chief executive officer of GrandCor, our parent holding company.

Currently, I'm chairman of the American Osteopathic Hospital Association's Committee on Hospitals with Teaching Programs. Accompanying me in the audience is Mr. Martin A. Wall, vice president of government affairs for the American Osteopathic Hospital Association.

In that capacity, I am here speaking for the American Osteopathic Hospital Association today. I would like to thank you, Mr. Chairman, for giving us that opportunity, and I promise to keep my remarks short.

I'm going to try to summarize some of the important points that are contained in our testimony.

The American Osteopathic Hospital Association considers the treatment of medical education under Medicare as top public policy priority.

If major changes were to be made in that, we feel that it might have an adverse effect on the teaching programs set aside for the osteopathic profession. And we consider the osteopathic profession the only comprehensive alternative medical system available to the American consumer today.

You have heard Dr. Cohen talk about the osteopathic medical education model earlier so I won't repeat that. However, we feel its distinction in several ways. The mass majority of our teaching hospitals are relatively small community institutions. Only 4 of the 15 medical colleges offer operating hospitals. All osteopathic hospitals of more than 200 beds are teaching institutions. And 70 percent of those between 100 and 199 beds have teaching programs. Of our 200 hospitals, 111 are teaching hospitals.

These community programs are producing mostly primary care physicians. You have probably in previous hearings heard how many family practitioners or general practitioners the osteopathic profession has generated over the years. They did it before the word was popular.

As was observed earlier today, these physicians are going to be the first stop for the care of an aging population which is expected to expand considerably in the years to come.

Our physicians are practicing hands-on or wholistic care. Now nearly half of our physicians are in communities of less than 50,000 population. Thus, osteopathic medical education is producing physicians that Federal policy advocates.

The hands on aspect of the education extends down to the clinical clerk level also. Although as you heard earlier today in testimony, that has not been included in the current method of reimbursement.

While it's too early to judge finally the Medicare prospective payment system overall, we are facing some very realistic problems that are associated with that. We have all experienced drops in census, reduced lengths of stay, increasing outpatient activities. It's affecting our hospital's ability to meet increasing demands for medical education needs.

We have all heard about the intern crunch which is supposedly upon us. We have been approached by the various schools to, in effect, accept more interns. As one of the panelists observed today, there is a negotiation and an act of negotiation going on between the management of the institution and the directors of medical education or the deans of the various departments. There is not a willy-nilly movement to increase those programs without considerable thought and foresight.

The AOHA supports the current payment mechanism for graduate medical education and urges that any changes await studies which are already underway. Under any policy changes, such as a grant mechanism, we would urge that the principle of separate but equal for the osteopathic profession be preserved as it is in the present certificate of need legislation.

We also urge that the type of physician that we are training, the general practitioner and primary care physicians, be considered in any policy scenario. And we are really confident that that will be done.

We pledge our data and assistance in participation with this committee in its endeavors.

Thank you for the opportunity to present our views.

Senator DURENBERGER. Thank you very much.

[The prepared written statement of Mr. Minor follows:]

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STATEMENT OF THE

AMERICAN OSTEOPATHIC HOSPITAL ASSOCIATION

BEFORE THE

SENATE FINANCE SUBCOMMITTEE ON HEALTH

ON

MEDICAL EDUCATION FUNDING BY THE MEDICARE PROGRAM

October 1, 1984

Introduction

Mr. Chairman, I am Richard J. Minor, President, Grandview Hospital, Dayton, Ohio, a 452 bed osteopathic teaching hospital. I am also Chief Executive Officer of GrandCor (Grandview Hospital's parent organization), as well as the current Chairman of the American Osteopathic Hospital Association's (AOHA's) Committee on Hospitals with Teaching Programs. Today I am speaking on behalf of the AOHA, the national organization representing the more than 200 osteopathic hospitals in the United States. Accompanying me is Martin A. Wall, AOHA's Vice President for Government Affairs.

It is my pleasure to be with you today to present the osteopathic hospital perspective on issues pertaining to medical education - the most critical policy area facing our profession.

Osteopathic Hospital Profile

Osteopathic hospitals serve as the primary institutional care facilities for those individual consumers who choose to receive their care from the 21,600 practicing osteopathic physicians in the United States. Osteopathic hospitals have nearly 25,000 beds available and in 1983, treated about 845,000 inpatients and nearly 4 million outpatients. In this era of competition, osteopathic medicine represents the only recognized comprehensive alternative to traditional medical care.

Our institutions and medical profession emphasize wellness and preventive care resulting in a "patient oriented approach" to medical treatment. Osteopathic hospitals provide a health care choice to the American people based on a distinctive medical philosophy offering patients a personalized, wholistic, "hands on" approach. With many of our hospitals located in rural and semi-rural areas, and with nearly half of our institutions having less than 100 beds and 80% having less than 200 beds, the osteopathic hospital profile reflects a very special community

orientation. The fact that nearly 90% of practicing osteopathic physicians deliver primary care with half practicing in communities of less than 50,000 persons, is further evidence that our profession is on the cutting edge of community health care needs. With this backdrop, it is our pleasure to convey to the Subcommittee the trends we see developing in osteopathic teaching hospitals; a description of the osteopathic model; an explanation of the vital role medical education plays in our hospitals; and, the effects of current Medicare policy on the osteopathic teaching institution. We will also present our evolving thoughts on options under consideration in the federal policy arena.

The Osteopathic Teaching Hospital

The training of tomorrow's general practitioners and family physicians is a top priority for osteopathic hospitals. Federal policy regarding the treatment of medical education costs was the Association's major policy concern during the deliberations on Medicare prospective payment and continues to be today. The reason for this is evident when examining the role osteopathic hospitals play in training osteopathic physicians. Of the 200 osteopathic hospitals in the United States, 111 are osteopathic teaching institutions. The overwhelming majority of our teaching

hospitals are community facilities and not academic health centers. In fact, all of our community hospitals with 200 - 299 beds are teaching institutions, while 70% with 100 - 199 beds have teaching programs. Only four of the fifteen osteopathic medical colleges currently operate teaching hospitals.

When considering policy regarding the financing of medical education under Medicare, AOHA believes that the needs of the smaller community hospital with a teaching emphasis should be reflected.

The Osteopathic Teaching Model

The osteopathic teaching hospital role in training general practitioners and specialists begins during the osteopathic medical student's undergraduate training. Our educational model stresses clinical exposure through externships and clinical clerkships. This type of hands on clinical education is an essential ingredient to train the osteopathic physician. As recent news reports have indicated, traditional medical education is being criticized for not emphasizing "hands on" exposure. Unfortunately, current federal policy is already having a negative impact on the further development of these needed clinical experiences. The Health Care Financing Administration has defined

such clinical training of students enrolled in medical education programs as a normal operating expenditure of hospitals. Thus, the funding of such undergraduate clinical clerkships must be supported directly from the prospective payment rates. With the census dropping in osteopathic hospitals nationwide, and pressures to curtail certain services growing, our institutions are finding it increasingly difficult to support these essential undergraduate medical programs.

The osteopathic hospital has traditionally had primary responsibility for conduct of internships and residencies. Under the osteopathic graduate medical education model, all osteopathic physicians must engage in a one-year rotating internship during which they receive clinical exposure in a multitude of medical areas. This builds the foundation for the general practitioner - the backbone of the osteopathic profession. Completion of the rotating internship allows an osteopathic physician to practice general medicine under all federal statutes and all state statutes with the exception of New Hampshire, where two years of post-graduate training is required for all physicians.

Residency training, especially in the primary care specialties, is playing an increasingly important role in our teaching hospitals. While our general practice model consists of a one-year rotating

internship followed by a one-year residency, other specialties require from two to six years additional training. The average length of osteopathic residency programs is 2.5 years.

There are currently 1,408 approved osteopathic intern positions and 1,688 approved residency training positions. These positions are approved by the Bureau of Professional Education of the American Osteopathic Association (AOA), the accrediting arm of our profession.

The Intern "Crunch"

The osteopathic profession is now facing a crisis regarding the long term ability of our osteopathic teaching hospitals to provide the necessary intern and residency programs needed for our new physicians. Our hospital system is not growing and, in fact, will likely be reconfigured as the pressures of Medicare and other financing programs take further hold. Osteopathic hospitals are faced with the dilemma of reacting quickly to external demands to constrain programs while meeting an increasing demand to train needed osteopathic physicians. This has resulted in an intern "crunch" in our hospitals.

Historically, about 6-7% of AOA approved intern positions nationally remain unfunded in our hospitals. In 1984, that figure has reached 13% due to declining census, shorter lengths of stay, a shift toward ambulatory services and concerns about future funding. Our profession is attempting to work out these problems within the osteopathic family, but the options are limited. Obviously, any federal or state policy initiatives that limit payment for teaching purposes will further exacerbate our problems.

Current Federal Policy

Under the present Medicare prospective payment law, osteopathic teaching hospitals are treated no differently than other teaching hospitals. It is really too early to fully evaluate how the current payment system is working in our hospitals, however, the effect on graduate medical education is being felt. In order to remain competitive, it is becoming increasingly difficult to provide quality internship programs with a significantly reduced census and an inadequate case load for teaching purposes.

The Association continues to support the exclusion of direct medical education expenses from the prospective payment system and the additional payment for indirect education expenses. We

believe that this adjustment is still needed for the same reasons that the Congress saw fit to include it when enacting the prospective payment system. Tests and procedures ordered by interns and residents, the demands placed on other staff as they participate in the education process, and other related expenses continue to be legitimate costs.

AOHA believes that any change in federal policy should await further study. Hopefully, the five-year federally funded study of the cost of graduate medical education currently underway will be helpful in evaluating these issues. One question the study may answer is how well current case mix indexes measure the severity or intensity of cases treated in teaching hospitals. While severity of cases should be a factor in determining whether teaching hospitals should be treated differently under any payment system, we do not believe it should be the only criterion. Our hospitals are community institutions, and ninety percent of our physicians are being trained in primary care. Federal policy emphasizes the need for primary care physicians. We feel the training we are providing is consistent with that aim and should be reflected in any formula for payment to teaching hospitals.

Perspectives on Potential Policy Options

Mr. Chairman, during this early examination of possible alternatives to the current reimbursement formula for graduate medical education, AOHA would like to offer our preliminary perspectives on several general policy thrusts that have been discussed and debated informally. We realize that no formal proposals have been introduced or reviewed by the Subcommittee.

One alternative to the current payment system is the establishment of a medical education grant program, possibly in the form of a block grant to states. Under this concept, states would receive an allocation of money based on the number of filled intern and residency positions at hospitals. States would disseminate the bulk of funding directly to hospitals based on the number of training positions available. From the osteopathic hospital teaching perspective, the great disadvantage to this approach is the fact that our hospitals have a relatively small number of training slots. This could present a serious problem to such hospitals if the size of a hospital program was the basic factor considered in determining payment. We are also concerned that politics could play a large part at the state level in determining which teaching hospitals would get grants. We would urge that the established federal principle recognizing that the needs of

osteopathic hospitals be considered on a separate but equal basis be a fundamental aspect of any such program. This principle is a component of the certificate-of-need program and requires proposals of osteopathic hospitals to be judged solely on the need for osteopathic services and facilities in a given community.

Another scenario would be to fund medical education programs through tax revenues. It could be argued that this is a fair approach since all tax payers would be subsidizing medical education. However, this would necessitate the acceptance of the principle that the country as a whole would be willing to accept the training of physicians as a national need. Again, politics could play a part in such an approach especially in light of shifting moods regarding tax policy.

Another proposal would utilize a professional peer review process to award federal funds for medical education activities. The key for osteopathic teaching hospitals under this notion would be the identified criteria utilized in deciding which hospitals receive federal funding. Again, we feel there might be a built-in bias against the osteopathic teaching hospital in favor of the larger, academic institution. Our hospitals would need to be assured that our applications would be treated in a distinct fashion and in terms of the need for osteopathic services.

Conclusion

Mr. Chairman, the American Osteopathic Hospital Association understands that this hearing is a preliminary view of the overall issues facing medical education under Medicare. We urge that the osteopathic training model be considered in any future deliberations on these critical issues. We strongly feel that our teaching programs are producing the types of physicians that this country needs. The emphasis on primary care and providing service in medically underserved areas is a historical role of the osteopathic teaching hospital. We hope the Subcommittee will continue to consider how our alternative medical system is providing a real health care choice for the American people.

We thank you again very much for the opportunity to present our perspectives on this critical issue.

Senator DURENBERGER. On page 7 of your testimony, Mr. Minor, I noted that 13 percent of your approved intern positions are unfunded. I wonder if you could explain that a little further. Do your institutions not receive payment for stipends and salaries and so forth that result from internship?

Mr. MINOR. No, we do. It's the question of the intern crunch and an increasing demand for positions. And there have been several institutions in the profession—I probably shouldn't say several. It would be more accurate if I should say a couple—which have made the decision to discontinue their medical education programs because of the economic environment that they feel they face. And as a result of that, with the increasing numbers of interns coming onto the marketplace, and with a couple of institutions ceasing to participate, institutions such as ours are asked to expand their programs. And some are declining to do so for a variety of reasons.

And that leaves unfunded positions.

Senator DURENBERGER. You don't, I take it, then have the same sort of claim to high intensity in the patient care requirement at your teaching institutions that we would hear from Mr. Everhart and some of the other hospitals.

Mr. MINOR. Well, there might be two observations on that, Mr. Chairman. One is that in the smaller hospitals, you will probably see a trend to keeping patients longer that normally used to be sent to the larger teaching institutions, for obvious reasons. In addition to that, in institutions such as the one that I manage, I think we have exactly the same problems, although we don't have the same number of very large institutions.

Senator DURENBERGER. Mr. Everhart, I take it the American Hospital Association position right now is sort of a no position. It is sort of too early to say that there is anything wrong with the current system, and also too early to say that there ought to be some changes and specifically what those changes might be. Is that correct?

Mr. EVERHART. I think that's quite accurate, Mr. Chairman. The fact is that a lot of hospitals in the country have just gone on the DRG prospective rating system the last 3 months. I think that is inadequate to really judge what impact that is going to have on a lot of hospitals. I, for example, just went on DRG's at the first of September. We were fortunate to have a fiscal year that begins on September 1, so we have a bit of a grace period.

But I think the other point that I would make is that we as an association are very much a part of and concerned with the study that the AAMA and COTH are doing and the newly created committee there is one which is supported totally by the AAHA. And I think we are waiting what comes out of the deliberations of that group as well as what finally comes out of the Arthur Young study. We are very interested in that study, and we have seen preliminary results which certainly are not extensive enough to reach any conclusions from them.

Senator DURENBERGER. But your association represents users as well as providers. And is there something going on within the American Hospital Association to address what could at some point be a potential for conflict between the institutions that are educators and the institutions that are users of services? Or is it just—

I'm trying to lead up to asking you to respond to some of the questions that were proposed earlier to some of the people about what's the marketplace out there for residents and interns, and who is in control of the marketplace right now, and what is this negotiating process that I have heard about. And in whose favor does it work.

And my problem is that I sit here believing that I have been pretty generous with medical education. Although it's only 25 percent this year, you can't feel the generosity yet, but by next year and the year after you certainly will. [Laughter.]

Senator DURENBERGER. And I wouldn't want you to get the notion that it is going to get more generous or for the association to get the notion that it might get more generous beyond that period of time.

Is there not some potential for difference within the hospital association as between the providers?

Mr. EVERHART. Oh, absolutely. The American Hospital Association represents over 6,000 institutions in this country, only 400 or so of which are the biggies in terms of the teaching hospitals, as being defined by the numbers of house officers and so on. So there is a real potential within the AHA for all kinds of conflict. But then there always has been because it has represented the intercity; it has represented rural institutions; it has represented chains; it has represented the for profits. It is all things for all people. And I think they do an amazingly good job of synthesizing the needs of those various institutions and assisting Congress and other public agencies in the country to arrive at some reasonable policy.

But within the AHA there are all kinds of factions, each one of which is concerned about its future, and each one of which is spending a lot of time deliberating on——

Senator DURENBERGER. I didn't want to take in factional politics because I assume that exists and that all the folks that we see do an excellent job of communicating without letting us know there are those factions. [Laughter.]

Senator DURENBERGER. But I would like for you to describe for us, without describing the factional politics, in an economic sense the need that the 6,100 have or the 5,700 have for the 400. And just how that interrelationship is working today.

Mr. EVERHART. OK. I think that interrelationship is a traditional one, and I believe it is one that is generally accepted. The fact is that the teaching hospitals are the institutions which do, in fact, educate and train the physicians which staff and populate the balance of those institutions around the country. And that's part of our mission. It's part of our goal. It's part of the purpose that teaching hospitals have.

Sure, we transport our product. There are seven medical schools through the city of Chicago. There is no way that the graduates of those schools and the graduates of the teaching hospitals associated with those schools are going to stay in Chicago or Illinois to practice medicine. They are, in fact, exported to the rest of the country, and that's part of our function.

On the other hand, I think hospitals around the country do, in fact, accept and recognize that teaching institutions, such as those that are represented by COGA or such as those which are repre-

sented by me, have a function of education of physicians upon which they are quite dependent. And that's recognized within AHA and it's recognized within, I think, the family of institutions that are our hospitals in this country.

Senator DURENBERGER. Two things are happening, of course. One is we are changing the prospective payment system and we are hitting harder at the 5,700 then we are hitting at the 400. And, also, there is this element of choice of health plans out there. And the increase in preferred provider organizations and so forth.

At some point, it seems to me, even in Chicago that might have an impact on the way Blue Cross or somebody else buys hospital services. At that point in time, it strikes me that it becomes an issue for this 5,700 to address in some way because I take it they need some of the rest of these people. And yet they don't want to have to participate in paying for those services directly if they can help it. Some States, when they see this competition coming and they see the cost of graduate medical education or the cost to the poor staring the politicians in the face, turn right around and say, well, we ought to solve that one. We will just add a tax to every visit to a hospital, or a tax to every visit to the doctor, or a premium tax on insurance. And then right away the cost of getting into hospitals increases in order to keep seven hospitals in Chicago going.

Is that a likely scenario? And, if so, do you know how the AHA is going to be able to respond to it?

Mr. EVERHART. Well, to answer the second question first, I do not know how the AHA will respond to it. I'm not sure it's an accurate scenario. Certainly hospitals such as mine are increasingly concerned about our competitive position. You are familiar with this dilemma in the Twin Cities certainly. The University of Minnesota hospital has been slow to respond to some of the pressures for cost reduction and new alternative delivery systems. And as a result, its occupancies are a problem. And its costs are a problem.

The same thing is true with reaching hospitals around the country. I think all of us are experimenting with the new alternative systems, with PPO's, with HMO's. And we are mindful that we have got to be more competitive with community institutions in terms of our pricing policy.

This means that there has got to be a certain amount of downsizing. It means that we are going to have to reduce current levels of expenditure. It's going on in every teaching hospital that I'm aware of.

And at the same time, we have to continue to offer programs which continue to attract patients into our particular kind of environment. You do that with cost competition. You also do it with quality. And one of the things that doesn't get said perhaps because it's politically difficult to enunciate is the fact that a good teaching hospital attracts good physicians who in turn provide good medical care. And I think generally people in the communities that we are serving understand and appreciate that. And, hopefully, over time will be able to pay some premium for that kind of quality.

I don't know if that answers your question. I think the AHA, as a body, has a real problem with its variegated constituency in ad-

dressing that issue because there is one group that is working on teaching problems and another that is working on innercity problems and so on.

Senator DURENBERGER. Two other questions, and it probably applies to both of you. Do hospital administrators see residents as presenting payroll expense problems, collective bargaining problems, malpractice premium problems, ancillary test add-on problems? Are they perceived as having a down side as well as an up side?

Mr. MINOR. Dave wants me to take that one first. I think in all candor the answer to that, generally speaking, is "yes." I think all those issues come to bear in either every element or specific ones over a period of time.

I don't think that those that are controllable are going without attention, though. I know that in many of our institutions today you will find specific educational programs designed and developed to make the intern and resident stay more responsible and responsive to controlling this phenomena of "over-ordering tests," to the degree that that can be done while they are still in a learning environment. In fact, in preparation for this meeting I read an article in the New England Journal of Medicine which was a highly statistical approach toward that very phenomena. Obviously, they are an expense. We see them as an expense.

I think our challenge, along with that of everyone, is to get the most bang for the buck, if you will excuse the expression, out of the product that we produce. And this is why it's important to us that some of the studies are in part zeroing in not just on the intensity or the severity of care, but are considering such elements as what types of physicians should be trained and what specific environment should they be trained in, and in what specialty should they be trained, or family practice emphasis.

So I think in answer to your question, if I have answered it, is that all of those are a factor, but are being dealt with as individual elements of emphasis.

Senator DURENBERGER. Right.

Mr. EVERHART. I think I would answer a little differently. I think on balance those problems which you enunciated are on the down side or are balanced on the positive side by the contributions that house officers make. And on balance, I am still, as a hospital director, very much concerned in trying to find the resources to support that process of teaching and learning in a hospital that we know as graduate medical education.

Now, sure, we have to be concerned about where to find money to meet a payroll and the numbers game. And we do exercise control on numbers and growth.

We are very much concerned about utilization review in utilization of ancillary services. But I think the same utilization concerns apply frequently even more arduously to senior staff than they do to house staff.

Malpractice, our experience has not indicated that although they get involved in malpractice actions, they are not the target nor the cause of malpractice as nearly as frequently as other more mature physicians.

So I think on balance, even as a manager and a guy concerned with the budget of our institution, they are a positive asset.

Senator DURENBERGER. All right. Thank you both very much for your testimony, your written testimony as well as your response to the questions.

I believe that concludes the hearing. The hearing is adjourned.

[Whereupon, at 4:49 p.m., the hearing was concluded.]

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